INDIANA MEDICINE

The Journal of the Indiana State Medical Association

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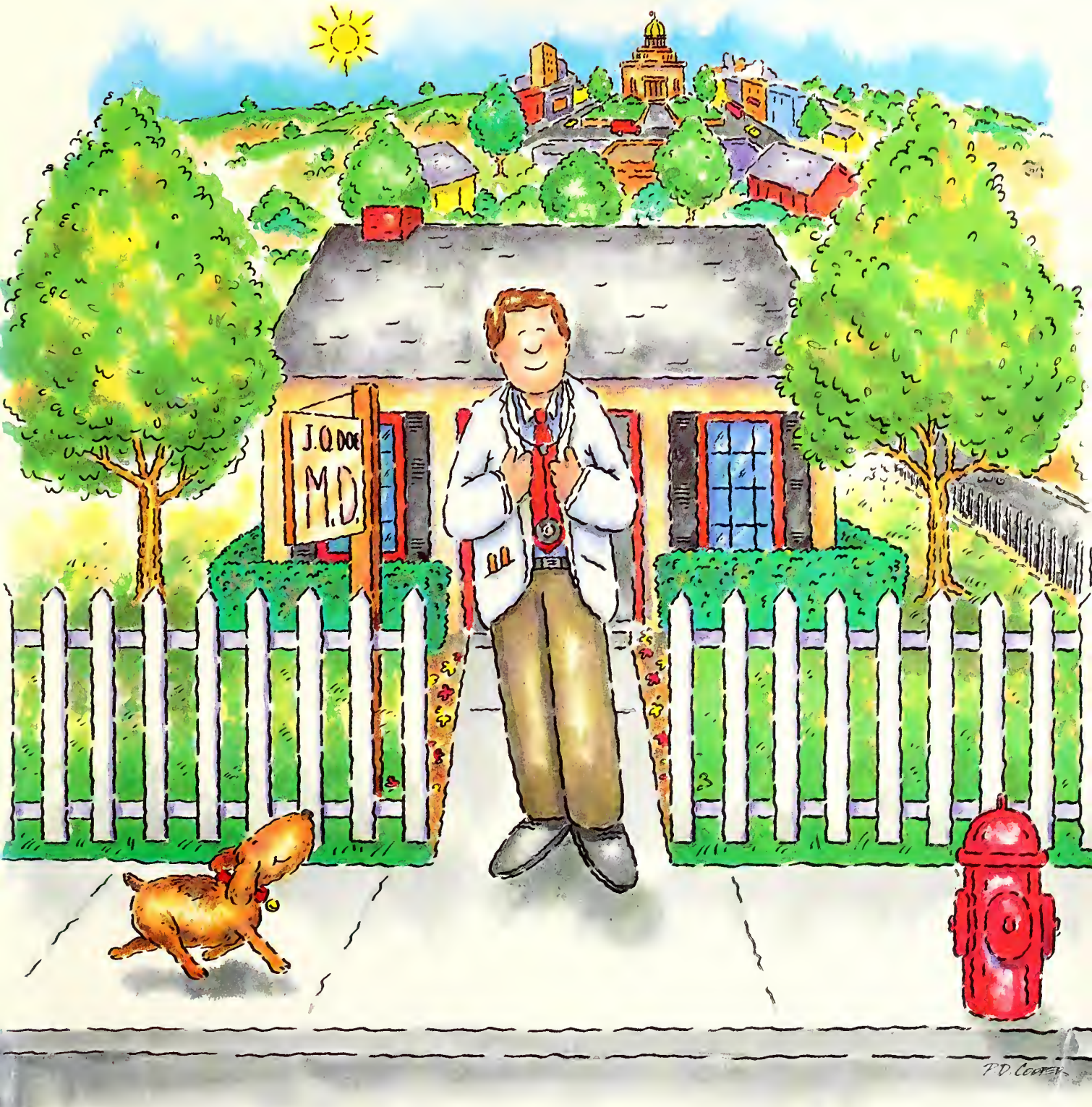

How solo physicians view their practices

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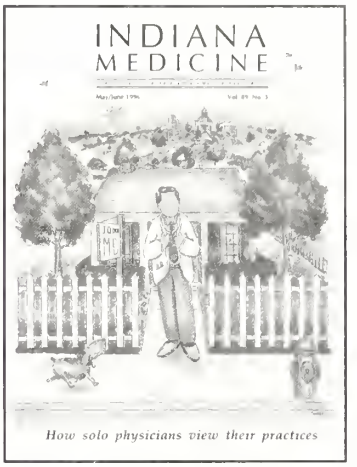
features

scientific contribution



Cover story begins on page 250. Illustration by P.D. Cooper of Bloomington.

departments

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Devoted to the interests of the medical profession and public health in Indiana since 1908.

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CME credit to be offered at 1996 ISMA convention

The ISMA and the Indiana University School of Medicine will co-sponsor four continuing medical education activities at the 1996 ISMA convention, to be held Oct. 18-20 at the Westin Hotel in Indianapolis.

David B. Nash, M.D., the first director of the Thomas Jefferson University's Office of Health Policy and Clinical Outcomes in Philadelphia, will speak during the opening session of the ISMA House of Delegates Friday, Oct. 18. Dr. Nash has been nationally recognized for his work in managed care, outcomes management, medical staff development and quality-of-care improvement. He serves on an expert panel convened to advise the AMA on its Physician Performance Assessment program.

"Health Care Delivery System Options," "Practice Acquisition" and "Best Health Care Practice Benchmarking" are the other CME programs. They will be offered Saturday, Oct. 19.

Watch your mail for more information on the convention.

ISMA practice management seminar focuses on capitation

Which reimbursement model is best for you? How can you become more profitable under a capitation contract? How can you avoid conflicts and negotiate effectively with managed care executives? These questions and more will be answered at "How to Roll the Dice and Win With Capitation," a practice management seminar to be presented by the ISMA June 7 at the Adam's Mark Hotel in Indianapolis.

Stanley Pappelbaum, M.D., Rancho Sante Fe, Calif., a pediatric cardiologist who develops physician contracting organizations, will discuss how risk-taking can put physicians in the driver's seat. Nathan Mowery, J.D., of Krieg, DeVault, Alexander & Capeheart of Indianapolis, will explain what risk pools exist and how physicians can negotiate a share in the profits left in these pools at the end of the contract period. Kam McQuay, C.P.A., of Blue & Co. in Indianapolis, will discuss how to approach a market, set a price and retain responsibility for providing health care services within that price.

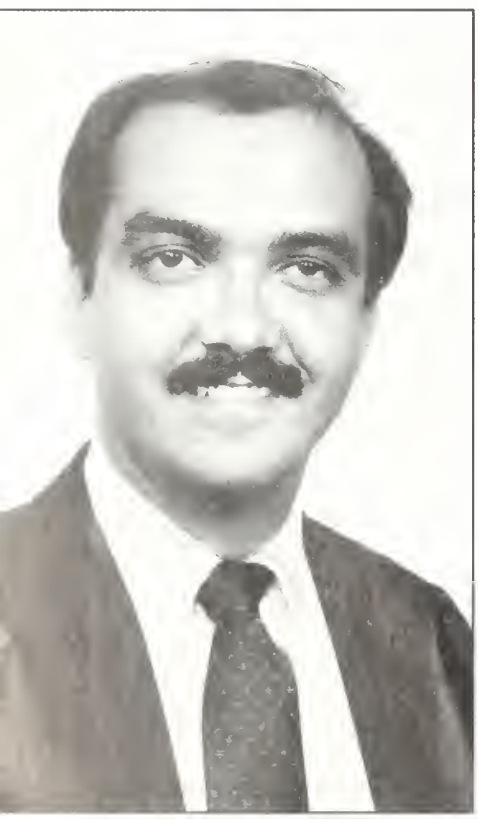
For information on this or any other ISMA practice management seminar, call the ISMA, 1-800-257-4762 or (317) 261-2060.

Correction

The January/February 1996 issue of *Indiana Medicine* stated that ". . . physicians and other health care providers have encountered significant delays and errors in Medicaid reimbursement, resulting in bankruptcy in some cases." This information was taken from an Indiana General Assembly Legislative Council Resolution, but the Indiana State Medical Association could not find evidence of any physician bankruptcies resulting from Medicaid reimbursement problems. We regret the error.

Managed care needs

Bob Carlson
Indianapolis



If the questions in this interview sound like ones you've been wanting to ask about managed care, it's probably because they were submitted to *Indiana Medicine* by practicing Indiana physicians.

To get some answers, we went to Mark A. Hochstetler, M.D., president of managed care services with Parkview Health System in Fort Wayne since June 1992. He is responsible for managed care operations and 60,000 covered lives in Indiana and Ohio. Parkview Health System is a not-for-profit tax exempt corporation, with three hospital affiliates in northeast Indiana. Dr. Hochstetler is also chief executive officer of Parkview Memorial Hospital's Signature Care PPO and medical director of the Parkview PHO.

Before he joined Parkview Memorial Hospital in 1992, Dr. Hochstetler was medical director and vice president for the central U.S. managed care subsidiaries of Lincoln National Corporation in Fort Wayne. From 1988 to 1990, he held part-time positions as associate medical director and manager of health services with Key Health Plan HMO in Indianapolis while practicing as a family practitioner.

A graduate of the Indiana University School of Medicine, Dr. Hochstetler is a member of the American Academy of Family Physicians, the American College of Physician Executives and the National Association of Managed Care Physicians.

Although Dr. Hochstetler may say things you don't want to hear, he hopes you will come to share his view that managed care offers physicians incredible opportunities to impact the future of their profession.

Indiana Medicine: What's your definition of managed care?

Hochstetler: My definition of managed care would be any organized attempt to match up health care delivery with a network of selected providers who agree to be accountable for both the clinical outcomes as well as, depending on the network arrangement, the financial accountability for the care. That covers a fairly broad set of arrangements that are out there. Some people would argue that only HMOs are truly managed care, but I tend to define it fairly broadly. I view managed care as a continuum of arrangements that include PPOs, POS plans, HMOs and other weird arrangements.

Indiana Medicine: How does managed care differ from capitation?

Hochstetler: Capitation is simply one form of reimbursement under a managed care arrangement, although you can't look at it simply as a reimbursement arrangement because capitation managed by providers forces a comprehensive review of everything you do in health care. It implies a limited set of providers. It implies not only accountability for clinical outcomes, but clearly accountability for financial results. It forces you to carefully examine the process of clinical care and the roles various providers play in the process.

Managed care isn't a monolithic arrangement. It is an entire set of tools to improve the way care is delivered and financed. HMOs are simply an insurance mechanism or arrangement to accomplish part of what managed care aims to do. There are a whole

variety of mechanisms to do that. Indiana currently recognizes two. It registers and regulates PPO arrangements and regulates and very closely monitors HMO arrangements. They are just insurance mechanisms.

Indiana Medicine: Capitation is a word that seems to strike fear into the hearts of physicians, particularly in areas like Indiana where maybe it hasn't penetrated as far as in some other areas of the country. Can you briefly discuss capitation from a physician perspective?

Hochstetler: Capitation is viewed by many physicians as an unknown evil. They've heard a lot of bad stories about it. One problem with managed care is that, like any new and emerging way of doing business, there have been a variety of entrepreneurs involved who have made a quick buck and gotten out. Some people have been hurt in capitation arrangements because they didn't know what they were doing, they didn't read the fine print, and they got burned.

As a physician, I think that capitation correctly administered by a provider-sponsored network can actually be better for patients because it allows the physician to allocate dollar resources to health care needs in a rational way. From an ethical point of view, I believe it is critical that capitation risk is assumed on a group basis, not on an individual basis. That allows the individual physician to act as the patient's advocate while meeting the group's expectation that they will practice high-quality medicine, which almost always costs less than poor-quality care that forces the clinical process to be repeated or intensified.

With fee-for-service, we're on a benefit plan that generally only pays for illness care, not for health care. The benefits are limited to whatever the insurance company or the employer decided they wanted to cover. Typically, you would find the plan doesn't cover immunizations, doesn't cover physicals, doesn't cover anything other than illness care because insurance was originally organized only to cover catastrophic events and illness. Insurance tends to be illness-oriented, not health-oriented. There's a saying in the managed care industry that the best way to reduce medical care cost is to increase health. Typical insurance programs don't really promote an increase in health status. Capitation is much more likely to promote this, especially if it is administered by a responsible provider group.

Indiana Medicine: How deeply does managed care have to penetrate a market before a physician practice becomes vulnerable to going out of business or other problems?

Hochstetler: The question makes the assumption that if I don't change anything in my practice and managed care makes an entry, how long before it becomes a threat to the well-being of my practice? To assume that you're not going to change the way you do business in a rapidly changing managed care environment is probably a mistake. In clinical medicine we deal with new drugs and therapies and new approaches to care all the time. To assume that the business side of medicine won't also change is probably a bit naive. Thirty percent HMO penetration of a market, without physicians recognizing that fact in their business planning, will pose significant financial challenges for the practice.

Indiana Medicine: How can a physician tell if his or her practice is vulnerable?

Hochstetler: The first thing a physician will notice is that the trend in income or net revenues from year to year will begin to flatten out or even begin to decrease. You're certainly seeing that in some of the metropolitan marketplaces here in Indiana, particularly with the subspecialties. That's mostly due to discounted fee-for-service reimbursement, where physicians have contracts stipulating the acceptance of payment in full from the insurer and collect nothing from the patients except a copay. These fee schedules are starting to flatten out or decrease. There's no capitation involved there. It's simply being paid less for what you do because there's significant competition from other physicians.

A second indicator would be that you'd actually see a shift in your payer mix. You would see more managed care contracting where payers are paying you an amount that is substantially less than your charges and that may move close to or below your costs. If you begin to see that segment growing in your market and in your practice, that's another sign that you may be vulnerable.

In this kind of marketplace, not knowing the actual cost of doing business is a real detriment. By that, I mean analyzing the work that you do and the care that you

provide, let's say on a relative value unit basis, so that you would know your cost per relative value unit. Most physicians don't know their costs. They don't know much about their fixed costs, variable costs or their margins, and they really don't know what their reimbursement is. They do know what their charges are, but I believe those are a poor basis for financial analysis. As managed care penetrates the marketplace to a greater degree, no one pays your charges anyway, so if you gauge everything by "this is a percentage of my charges," that's like talking about the manufacturer's suggested retail price on a car. GM doesn't report its financials back to its shareholders based on MSRP, they report it back on what they actually collect for a car. Physicians should look at their practice in the same way.

Indiana Medicine: How does a physician determine his or her cost of doing business?

Hochstetler: Like any other business, physicians need to know their fixed costs and their variable costs, because if you're asked to take a fee schedule or a capitation arrangement, your financial success will be directly proportional to your ability to manage your costs. The best way I could put it is that we're moving to a different costing or pricing mechanism than what we've had historically in medicine. We've always been in what I call a cost-based pricing (charges) mode, which meant we decided what price we would charge in the marketplace on a cost-plus basis. Historically, we've always said, OK, this is what it costs to run an office, to hire an office staff. That's my cost. I'm going to add my target income to my cost, here's the number of units I think I'm going to provide next year, and, voila, that's my charge. And we basically got paid that charge for a long time.

Today, we're seeing the flip side of that, where the purchasers, either directly as employers or through their agents, the insurance companies, are saying, "No, this is the price we're willing to pay, so you're going to have to take that price, whether it's a maximum fee schedule or a capitation amount, and you're going to have to control your internal costs in order to generate the net income that you want." We've never really had to deal with this before. I call if price-based costing.

That's probably one of the big lessons of capitation – you have to know your cost, because if your costs exceed or leave very little margin at the fixed reimbursement you're receiving, you're not going to do very well as ongoing business.

Indiana Medicine: All right, so a physician reads that Hochstetler says, "I've got to know my cost." What does that doc do? Does he call an accountant? Does he call a consultant? Does he tell his practice manager, "Go figure out my cost"?

Hochstetler: Any and all of the above. I can think of physicians here in Fort Wayne, including some who are solo, who have done it on their own. They've set up their costs and their fee schedule on an RVU (relative value unit) basis. You can pick Medicare or the McGraw Hill system to do the analysis – they're just tools to perform the analysis. Some large specialty groups have had their business managers do it themselves. Other physicians have used consultants. A solo physician can do it himself if he has the time, some good analytical skills and a good billing information system. But the point is they have begun to identify their costs of doing business.

Indiana Medicine: What can physicians do to position themselves for managed care?

Hochstetler: They can do a number of things. They need to know their costs, as I emphasized in the last question. They also need to know patient satisfaction data and use it to improve their practice. The Fort Wayne Medical Society is working on a project to see whether we can offer patient satisfaction surveys on a service bureau basis to the physician membership. The goal is to give physicians access to patient satisfaction data from a credible third-party source, which can be utilized in quality improvement efforts as well as a benchmark against the member satisfaction data gathered by managed care organizations.

Physicians must ensure that patients have adequate access to care, which involves both geography and hours.

In an increasingly competitive marketplace, knowing what kind of clinical outcomes you have achieved is important. The idea there is that we're all trying to achieve the highest obtainable clinical outcome we can for the lowest justifiable cost, and that involves some bench marking. If you're a cardiology group, [you want to know] how many cardiac catheterizations you perform com-

pared to a similar group, and what are the clinical results? How many of those are false positives? In other words, we thought they had heart disease, but when we did the cath, it was normal. There's always a certain number of those, but if you do too many, maybe you're being a little too aggressive in doing your heart caths. Again, we have to be able to demonstrate how good we are.

Everyone has always taken for granted that we're all providing the highest quality medicine, but purchasers are beginning to question whether that's really true. Is more necessarily better? Being able to demonstrate that you know how to provide good care management, having good communication skills, knowing how you compare with the competition – they are all important.

Being board certified is important. That's a pretty controversial area in medicine but it's certainly being demanded by the purchasers of health care, which are mainly the employers. Being able to demonstrate continuing medical education activities, that you're attempting to improve yourself, is important. What it really boils down to is showing that you provide the highest value to your customers, because you are more than competent internally. It's been hard for us to, one, recognize who exactly are the customers and, two, determine what is important to them. That's one of the challenges in medicine today.

Indiana Medicine: Let's say we have a small group or even a solo practice. What are the options for putting in place a mechanism that will generate the appropriate outcomes data, patient satisfaction data, etc.? Again, are we talking about consultants, or how would that work for somebody who wants to implement that in their practice?

Hochstetler: It's very difficult for a small practice to do that. Quite frankly, the level of organization needed to really get at those questions and get at the resources required is more and more requiring at least 30 to 40 physicians organized fairly functionally. The organization doesn't require a medical group with merged assets; it can be an IPA, MSO or PHO as long as everyone agrees to be accountable to each other and have common goals.

> *"The bottom line for physicians dealing with managed care is the need to get organized."*

You also have to look at how you interact with the medical care system. Medical care is very interdependent. Ear, nose and throat specialists don't stand separately from cardiologists who don't stand separate from family physicians. They're all very interrelated through and overlapping responsibilities for patients they care for on a joint basis. Within a single practice you can look at your cost, and then your problem, of course, is where do you find benchmarking data to compare your cost to somebody else. That's where a consultant or a good accountant can get involved, especially someone who specializes in health care services.

My advice to physicians is that they need to get organized. I don't mean in professional trade associations like the state medical association, which I think is fine for political purposes and other services the association provides, but for the business purposes of health care. You're talking about a $1.1 trillion dollar industry that consumes 14% of our gross domestic product. It's a big business; to think it's not is to kid ourselves.

The key to success in any kind of business, especially when it's rapidly changing, is some type of organization. What you see is physicians organizing themselves into PHOs, MSOs; you see providers in some areas actually getting their own HMO licenses or forming networks. If you get organized, you can share resources, expenses and expertise. You gain market leverage, and you make yourself more attractive to purchasers who would rather sign one contract instead of 200. The bottom line for physicians dealing with managed care is the need to get organized.

Indiana Medicine: What are managed care plans looking for in physicians? At a minimum, they seem to want board certification.

Hochstetler: That's true. It is an expectation driven by the report cards (HEDIS) being issued by HMOs to employers. One of the data items on the report card is the number of board-certified physicians in the HMO plan.

They're also going to look at access questions. Do you provide geographic coverage? For instance, if you're a cardiology group, do members of the group staff clinics

in outlying hospitals? What are your clinical outcomes? What are your patient satisfaction scores? Are you willing to accept the reimbursement arrangement? Can you accept the reimbursement arrangement and remain financially viable? In other words, do you know your costs?

You're also going to find that many payers assume that quality is the same across the spectrum. I've had large employers tell me unless you can prove that you're appreciably better or they are appreciably worse, we're going to assume that the quality is the same across the board, and the only thing to differentiate the services you provide is the price that you're willing to accept. A pretty cynical outlook, but I think a realistic one in an environment where there isn't a great deal of comparative data, where the employer doesn't really know how anyone defines value, and where the approach to the marketplace is to buy at the lowest cost, which everyone understands. In some cases, we have more capacity (both physicians and hospital beds) than what the system requires. Anytime you have an oversupply situation, price becomes the principal factor in negotiations.

Indiana Medicine: Once some fairly reliable or effective quality measures are instituted, does that mean you're going to have some attrition on the provider side?

Hochstetler: I think it is a potential for some segments of our industry. It's a little hard to read. You hear all the horror stories from the West Coast, but you have to be careful, extrapolating the West Coast experience to Indiana. Health care is very local and regional. To extrapolate you must understand the market forces in both locations and apply the experiences that are common. To apply broad generalizations or dismiss it all as totally irrelevant are equally dangerous approaches to strategic planning.

Indiana Medicine: Do managed care organization want a jack of all trades?

Hochstetler: In general, the answer is yes. The span of services defined by that phrase varies anywhere from being pretty broad for a specialty like family practice and somewhat more narrowly defined in basic cardiology. Unless you provide a very unique service that no one else can reasonably duplicate, there's going to be competition for those services. As a purchaser, the more value you offer my employees, in other words, the greater the spectrum of services in one place, the more competitive you're going to be.

Indiana Medicine: Can you give us an example?

Hochstetler: Let's take a specialty like ophthalmology. If you offer just one of the subspecialties in ophthalmology, you're vulnerable to competition in the marketplace unless you're absolutely the best at it and you can show a demonstrated track record that you have the best clinical outcomes at the most competitive price. Otherwise, you need to be prepared to offer approximately 95% of the services found in ophthamology.

Indiana Medicine: How long does it take managed care to expand, say, from 10% to 70% in a given marketplace?

Hochstetler: What I tell people is, if you look at southern California, which is a benchmark for a lot of people, you basically saw people move through the four stages of managed care over a period of about 10 years. Many people feel that in the Midwest those changes won't take nearly as long. There are a couple of reasons for that. One is that the mistakes have already been made out on the West Coast and the East Coast and the people involved are likely not to make some of the same mistakes again. They're smart people. The marketplaces out there are becoming very crowded, and so the same individuals who helped formed them – and they're not just consultants or insurance companies, they're also physician groups – are beginning to take that success record, those lessons learned, to other marketplaces around the country and make things happen. It's entrepreneurial activity and it's here in Indiana today. There's a large California IPA, the Heritage Medical Group, operating in Indiana in an attempt to organize the marketplace.

Indiana Medicine: What parts of Indiana is Heritage looking at?

Hochstetler: I don't know the extent of their activity exactly, but they are active in most areas of the state. In fact, they're in places people would find surprising.

Indiana Medicine: Why is that?

Hochstetler: In southern Indiana counties where you wouldn't think there's much managed care, Heritage is contracting physicians into

a physician IPA arrangement. They're a layer between the physician and the payer. Basically, they feel they know how to organize a marketplace and they feel providers in Indiana don't know how to organize themselves. They feel there is a business opportunity because they understand how care is provided and financed. They see an opportunity in a relatively immature marketplace to come in, organize how care is delivered, attach to that the willingness to accept accountability for the financial part of it, and basically make a nice living doing it.

You're going to see changes more quickly in Indiana than what you have seen in other markets. We shouldn't sit here and think that it's not going to happen in Indiana. If nothing else, we have an obligation to ourselves, our communities and our patients to ensure that health care dollars are spent on health care and dont't simply end up as bounty money in the pocket of an entrepreneurial health plan that took advantage of a disorganized provider community and a set of purchasers who were simply delighted to slow down the rate of increase in their premiums.

Indiana Medicine: What happens to physicians whose practices are owned by hospitals which in turn may be threatened by a managed care take-over. Is that a real life scenario here?

Hochstetler: It assumes that there are going to be a fair number of hospitals going out of business because of managed care coming to this market, and I would say that in Indiana that's not going to happen to a great extent.

If you look at Indiana in general, because of our history of certificate of need laws, the state controlled the proliferation of hospitals and facilities for 25 years, and Indiana in general doesn't have too many hospitals. We still have too many hospital beds, but the hospitals have been doing a good job of downsizing themselves to accommodate the marketplace.

As a result, physicians employed by hospitals and health

> *"We shouldn't sit here and think that it's not going to happen in Indiana."*

systems are relatively secure because of the capital available in the hospital. From a business perspective, they are in better shape than the majority of physicians, who have no financial reserves for capital investments. Most of the hospitals that would be threatened with going out of business probably can't afford the investment required to invest in physician practices.

Indiana Medicine: How does managed care affect a physician's income?

Hochstetler: It probably depends on your specialty. Primary care physicians are generally going to see their incomes stay fairly stable and perhaps even increase, depending on what risk arrangements they enter into. How much accountability do they want to accept for managing various patients in a delivery system and the finances that go with it? In other words, if you're a primary care physician, you can take risks for the services that you provide in your office, or you could take risk for all professional reimbursement, which would include all specialists that you refer to, or for the entire insurance dollar, which includes hospitals and facilities. Various physician groups have done that in various ways.

Specialists, I think, in general will see their revenues or incomes begin to flatten out and perhaps even decrease, although the forward-thinking specialists who join up with the right partners, get themselves into organized contracting arrangements and get access to capital, should do just fine financially.

Primary care physicians, at least for now, tend to be much better insulated against the possibility of decreasing income.

Indiana Medicine: How does managed care in Indiana differ from managed care in other markets?

Hochstetler: For one thing, we have a dramatically lower managed care penetration than all the four states surrounding us. It's very striking if you look at a map which shows the degree of managed care penetration in all 50 states. Illinois, Michigan, Ohio and Kentucky all have about 19% to 22% HMO penetration. Kentucky lags a bit behind that, but I think it is about 14% to 15%, and then you have Indiana at around 9% or 10%.

Indiana Medicine: How

"trapped" are physicians once managed care has penetrated a marketplace?

Hochstetler: They're as trapped as they want to be. Physicians have a real opportunity in front of them. I've moved in the last six years from being someone who was in clinical practice taking care of patients, but dabbling with managed care on the side as a career interest, to being involved in it full time today. That's my personal choice, but I genuinely enjoy helping other physicians approach managed care as an opportunity to improve both the clinical and the financial aspects of care. In fact, managed care is really just another evolutionary step in our transition to wherever we're going with health care in general. It's not an end in and of itself.

The point for physicians to appreciate is we've been very content for a long time to simply providing care to individual patients who we saw on a one-on-one clinical basis and with payment largely provided by a third party. We are now challenged with the premise that this old paradigm doesn't necessarily hold up as a sustainable strategy into the future. We've been very happy to accept payment for our services, but disengaged ourselves from the other aspects of health care financing. I don't think that's sufficient any more.

Physicians need to take a leadership role and be proactive, not reactionary, which is what we tend to do as a profession. When the Clinton health plan died, the federal government ceded health care reform to the marketplace. It's an incredible opportunity for physicians to step up to the plate. We need to develop some kind of vision of how we think health care ought to be provided and financed in our communities. Physicians are the key. As I tell people, the most expensive instrument in the hospital is not the newest MRI scanner the hospital just purchased. It is the physician's pen. That instrument controls 85% of health care costs. As a result, physicians have an incredible responsibility and an incredible opportunity to impact what goes on.

Indiana Medicine: How easy is it for physicians to move into a managed care market?

Hochstetler: If physicians want to get into managed care and become successful at it, it comes down to being organized, realizing that not everybody can or wants to participate in that kind of enterprise. The challenges for organized medicine are interesting in that state medical societies often look at whether they should organize managed care plans. The concern I have about that is the assumption that everybody can participate who wants to, usually on the basis they have a license and they are a member. How does a plan that includes everyone, regardless of the value they bring to the business enterprise, really compete in an increasingly competitive marketplace? The challenge is for physicians to look at what their external customers want for their answers – then plan and move forward accordingly. Pick your partners carefully, move forward deliberately and then run with your organization as fast and hard as you feel necessary.

Indiana Medicine: What is the enticement of managed care?

Hochstetler: For the purchasers, managed care offers an opportunity to get a handle on health care costs. Perhaps even more importantly, it gives them an opportunity to define and increase the value of health care.

Managed care is attractive to physicians who are willing to be accountable for the outcomes of health care, not just for the clinical delivery but also, to varying degrees, the financing of health care. It's enticing because, for the first time, you've got dollars to do things that you think are right, [such as] paying for immunizations, encouraging patients to modify their lifestyle and hiring staff to provide patient education. ❑

Bob Carlson is a health care writer based in Indianapolis.

How solo physicians view their practices

Bob Carlson
Indianapolis

You set your own hours. Go on vacation when you want to. Decide which managed care contract you're going to sign, which you're going to pass on. Your staff thinks it's time for a new practice information system? It's your call. Want to send your billing person to a refresher course on coding? Reduce your fee for an indigent patient? Cross-train your staff? You are the captain of your ship and you simply make it so. No executive staff meetings. No memos. No office politics. No muss. No fuss.

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When you look at a patient chart, you don't have to decipher someone else's hieroglyphics or guess at the gaps in the notes. Every single patient you see is yours and so is his/her history, diagnosis, treatment course, progress report, phone call and prescription. While their neighbors complain that they've never seen the same doc twice in that new HMO plan, your patients know who they're going to see when that exam room door opens. Your patients like it that way, and so do you.

These benefits keep many Indiana physicians in solo practice and far outweigh any negative aspects.

Yet more and more solo practitioners are joining various group practice models or accepting positions as employees of corporate health care entities. For the most part, these physicians seem to be reacting to larger trends, such as higher medical school debts, more red tape and the growth of managed care.

According to *Physician Marketplace Statistics* of the AMA's Center for Health Policy Research, 27% of physicians in the United States were solo practitioners in 1995, compared to 35% in 1990.

Although the urge to merge seems stronger than ever, thousands of solo physicians are still bucking the trends. To find out more about this increasingly rare breed, *Indiana Medicine* interviewed nine solo physicians in Indiana. This is an informal, decidedly *un*scientific sample. Here's what we found out.

Independence. Freedom. Autonomy.

These are the words C.M. Hocker Jr., M.D., a New Albany family practitioner; Tom Millikan, M.D., a New Castle general practitioner; and Thomas Ringenberg, D.O., a Huntington family practitioner, use to describe what they like about solo practice. Almost without exception, our solo physicians are a happy lot. Business is good, their staffs are the best, their managed care contracts are working out all right, and they love their patients.

For eight of the nine physicians we talked to, the advantages of solo practice outweigh the drawbacks. Three had partners or were in groups earlier in their careers. Looking back, they remember that overhead was astronomical and that there were a lot of chiefs and not enough Indians.

Still, some of the most ardent soloists admitted that they wouldn't mind having a partner, if only to share the overhead.

"It's not like I'm recruiting somebody," says Wayne White, M.D., a Connersville family practitioner. "But hey, if somebody comes along and is compatible, welcome aboard.

Grace Walker, M.D., a Terre Haute family practitioner, agrees that part of her would like to be in a group, too. "But," she says, "I don't want to be married to 50 doctors."

Oh, solo mio!

At first glance, being able to get away would seem to be a major problem for solo practitioners, and almost all of our interviewees did put coverage first on their list of disadvantages. Dr. Millikan says he sometimes goes six months without a day off (he admits he has a very understanding wife), but then his brother comes in from his internal medicine residency so the Millikans can take a vacation.

Most of our solos have managed to work out more conventional call-trading arrangements with colleagues in their communities. Dr. White, for example, has a contractual agreement with two solo colleagues in the area that gives him two out of every three weekends off. "It's automatic." he says. "At 5 p.m. on Friday, that pager goes in the drawer and I don't pick it up till eight o'clock Monday morning."

Dr. Walker says she has never missed a vacation with her family because she couldn't get coverage, but she still worries about getting burned out and managing her time.

Not being able to interact with

their peers on a daily basis is a drawback, but again, these solos see their relative isolation as one of the trade-offs they make for running their own practices. They simply pick up the phone and call whoever they want to consult with. "I have a line to IU Medical School and Harvard Medical School," says Sjoerd Roggeveen, M.D., a Kentland family practitioner. "I use them about once a month. Otherwise, I rely on my local specialists."

Then there's the bureaucracy and all the rules and regulations. For example, says Dr. Roggeveen, there's the OSHA regulation that requires anyone who draws blood to wear gloves, which makes it impossible to locate some of the smaller blood vessels by touch. Hospital technicians tell him they simply cut the fingers off the gloves before they put them on, which of course defeats the purpose of the regulation.

Not surprisingly, more than one solo physician also complained about overhead. Everything, from the rent and utilities to staff salaries and the computer system, comes out of a solo practitioner's revenue. "My overhead would drop by about a third if I could get somebody to share the rent," says Dr. White.

Tempting offers

For some solo physicians, there's another option. Three of the nine physicians we talked with have been approached about selling their practices, but only one is seriously considering it.

"I can't keep up with the paperwork," this physician says. "I think that's the issue. Regulations. Between the CLIA lab, which I've done away with – I couldn't make the inspector happy – then the insurance issues of coding and trying to keep that all up to snuff so that you don't get accused of fraud, so you end up underpricing things. It just makes it a little bit tougher in the long run, I think. Besides, everybody's asking about your practice now."

Dr. Walker, on the other hand, is convinced that the best of all worlds is the one she has created for herself after 11 years in practice. "I believe the best person to work for is myself," she declares. "I don't want to work for somebody else because somebody else always wants more out of me than I think I'm able to deliver and then they want to give me less."

The other solo who has been approached about selling is happy with the status quo but may change his mind if his situation changes.

"Boy, it's kinda tempting," admits Dr. White, who has had several offers. "But man, you gotta sell your soul. This crew that I have in here right now, I must pay them well 'cause nobody ever leaves and we have had no problems. The morale is good, everybody's happy. If I had a lot of turnover and I was having to hire and fire people, I'd be wanting to sell it in an instant."

Solos and managed care

Seven of our nine solo practitioners already participate in some managed care contracts, and so far, they say they're going OK. Beyond that, it's difficult to generalize about how our nine solos are responding to managed care.

"On the HMO type things, you have to be able to supply the capital," says Robert Heavin, M.D., a Coatesville family practitioner, "and if you have a couple of big risk problems, you know, one person can't share that kind of capital risk."

Brett Eaton, M.D., a Frankfort family practitioner, and Dr. Millikan expressed misgivings about the effect of managed care on patients and patient care. Dr. Eaton participates in three managed care contracts, and Dr. Millikan says he's not aware of participating in any, but that it's OK for any patient to sign him up for any insurance program.

"Patients just seem at a total loss what doctors they're going to actually see next," says Dr. Millikan. "I hear all kinds of stories from people. It really scares most anybody that I talk to."

Dr. Eaton concurs. "They don't really understand how the system works a lot of times," he explains. "I think the intent of the system is good, having a gatekeeper to keep the costs of medicine down, but I think in the long run, I've seen patients suffer from it. I don't think it's fair to them sometimes."

Some solo physicians are so concerned about being left out of managed care negotiations, and ultimately out of provider panels, that they're joining physician organizations (POs) and physician hospital organizations (PHOs).

"I think there's a risk in not being affiliated with a big group of being left out of some negotiations or managed care plans as managed care evolves and becomes more prevalent," says Dr. Hocker. "I'm in a vulnerable situation because I am solo, so I joined a physicians' organization that has several hundred physicians that contracts with managed care organizations. So far it's worked very well. Whether it will continue to work well, I'm not

Read fine print and train your staff, solos advised

If you intend to stay in solo practice, Michael Heaton of Heaton and Eadie, an Indianapolis CPA firm that provides services to physicians, has some suggestions.

Contract review and negotiation
Heaton's experience is that physicians can end up holding the short end of the stick because they don't read the fine print in the contracts they sign with third- party payers. If a contract gives the payer the right to change the fee schedule without the physician's approval, Heaton says physicians may not be aware that such changes were made.

"I don't think it's any secret that in Indiana, until fairly recently, we've been a classic everybody-signs-up-for-everything state. Very few contracts have been floated out to the physician population that haven't been signed and returned. Physicians are afraid that if they don't sign up for a particular program, they're going to be denied access to those patients, so they just sign up without reading the fine print or negotiating."

Payer monitoring
Which payers are you dealing with? Are you being reimbursed according to the provisions of the contracts you signed? How does one fee schedule compare to another payer's? Are you being paid on time?

"If we're not paying attention to the contract in its initial stages, it's normally reasonable to assume that we're not doing a good job of monitoring compliance with it,"

He says the best way to monitor payer compliance is to use software programs that automatically keep track of multiple fee schedule information.

Practice information systems
A good information system is critical, but it's more than a good computer. Heaton also includes policies and procedures to use that system and the information it produces effectively.

"It's not just a question of throwing money at computer hardware and software. It's also making sure that your staff knows how to use those devices to your best benefit."

Staff training
Many physicians who invest a lot of money in an information system don't allocate enough resources to train those who use the system. That includes continuing education on subjects such as coding and contracting.

"If I'm a solo practitioner and I'm looking at ways to preserve my income and therefore my lifestyle, the first thing most practitioners tend to do is to try to figure out a way to trim their overhead. We've seen a tendency in some practices, in an attempt to cut that overhead, to decrease the amount of staff training. I think that's being penny-wise and pound-foolish. Now is the time that our staff needs to be more educated in dealing with insurance companies and third-party payers and managed care contracts."

Market research
Do you know where your patients are coming from? If you're a specialist, do you have a good handle on all your referral sources, not only physicians, but other potential referral sources? Do you know who your competitors are?

"Knowing your business is not just knowing how managed care companies and third-party payers are paying you, but involves a knowledge of who your competitors are and who your colleagues are and an understanding of how you might be able to work together with those people."

Strategic alliances and partnerships
Heaton suggests that a solo practitioner can hurt his practice as much by missing out on potentially good opportunities to partner as by entering into a partnership for the wrong reasons. What are the right reasons? Business reasons.

"I don't think you should just summarily dismiss any type of invitation to participate in any type of meeting about any type of organizational formation, whether it's an IPA or

(continued on next page)

Read fine print and train your staff, solos advised *(continued)*

some type of practice affiliation agreement or a PHO or whatever. I think it never hurts to listen. But by the same token, I think you have to be very careful about who your partners are. Size just merely for the sake of size I don't think is what we're after here. We're after the best way to run our practice."

Administrative support
Being a solo practitioner does not mean a physician is responsible for all day-to-day business operations of his practice. The trick, says Heaton, is to surround yourself with people whom you can rely on to look out for your best interest.

"You can always look to outside consultants such as those provided through ISMA's Second Opinion Program, but at a minimum, I think we need to look hard at our internal staff and make sure that we're getting good advice from them on our practice operations on a daily basis."

Professional representation
For physicians who are thinking about selling their practices, Heaton strongly recommends professional representation in both the legal and financial areas.

"Normally, you're dealing with someone who has acquired other practices, who has some very definite objectives and ways that they want to do things, and that's fine. But I think that it's very important you have someone representing your interests in those negotiations as well." ❑

sure. It's something that I keep my eye on."

"I can see thunder on the horizon," agrees Dr. White. "I know managed care is on its way and it's going to be an inevitable part of my future. At this point, I have zippo contracts with managed care, but we've just started what we call this physician hospital organization with all the physicians in Fayette County. We're going to try to negotiate directly with the local industries for a piece of the health care dollar."

Other solos figure they've got a few more years before the full force of the managed care tide hits Indiana, especially those who practice in smaller towns and rural areas. If they're the only physicians for miles around, they tend to feel more secure about the future than their colleagues in more densely populated urban areas and don't see managed care as an imminent threat.

Then there are physicians like Dr. Walker who are confident that there will always be a demand for their services, come what may. "Everybody's saying that if you don't belong to a group, then you're going to be left out of managed care," she says. "I believe I'll always have patients to see because I'm a good doctor and I take good care of people. Managed care may change how I get paid, but no matter what you call it, it doesn't change how I take care of people. I believe there is a place for me in managed care because I'm good with patients, with utilization, and with documentation."

Project Solo
Good physicians all over the country and here in Indiana are finding out that managed care (please see interview with Mark Hochstetler, M.D., in this issue of *Indiana Medicine*) can be a Pandora's box full of unpleasant surprises. Happy patients, great outcomes and cost-effective utilization are one thing. Substantiating these measures with the data that payers want to see is a whole other ball game, one that most physicians in Indiana are just learning to play.

The sophisticated data-gathering and number-crunching systems that provide this information are beyond the reach of most independent physician groups and solo practitioners. That's why Steven Isenberg, M.D., one of the nine solo practitioners interviewed for this article, started Project Solo. Dr. Isenberg, an Indianapolis otolaryngologist, believes that the best way to preserve the role of physicians as independent patient advocates is to preserve independent and solo physicians.

"If we all become several giant groups," he says, "we can be easily manipulated into providing the kind of care that is dictated by an employer, whether it be a managed care company or an HMO or a hospital."

Project Solo members submit electronic claims, outcome survey and patient satisfaction survey

data, which are analyzed and compared to existing data. Members then receive confidential feedback on quality of care and cost containment. Since he started it in 1994, Dr. Isenberg says Project Solo has grown to include physicians in about 37 states.

"I'd like to urge not only solos but independent physicians practicing in groups to weather the storm and handle their practice more like a small business," advises Dr. Isenberg. "I think we still have the opportunity to control health care for patients, which is our obligation, but we have to get our own house in order, and hopefully the market will come back to us."

A prognosis for solos

Helping physicians get their houses in order is how Michael Heaton makes his living. He is a shareholder in Heaton & Eadie, an Indianapolis CPA and consulting firm that provides services to the health care professions in Indiana. He has been representing physicians exclusively for 15 years.

His advice to solo physicians focuses on developing a more businesslike approach to the revenue side of the practice (please see box), including

- contract review and negotiation;
- payer monitoring;
- practice information systems;
- staff training and development;
- market research;
- strategic alliances and partnerships;
- administrative support; and
- professional representation.

"Right now, I would continue to be open to discussions about affiliation opportunities, maintain a good dialogue with colleagues and make sure that you have a good understanding of the economics of your practice," advises Heaton.

Is there a future for solo physicians in Indiana?

"I think there are always going to be situations where solo practitioners and smaller groups can do well," Heaton responds. "We have a very decentralized medical community in Indiana. We have smaller groups of physicians than other areas throughout the country. I think there's a future for solo physicians, but they're going to have to become more sophisticated in how they run their business. Without some sophistication in the financial management of practice, I see practices having erosions of profits and net income, and I think it's going to be difficult to maintain the type of margins that we've seen over the last several years." ❑

Bob Carlson is a health care writer based in Indianapolis.

How solos see the future

"More of a managed care environment and some capitation type systems." – *Brett Eaton, M.D.*

"I don't see anybody practicing solo as we knew it when I started 15 years ago." – *Robert Heavin, M.D.*

"There are going to be a few large conglomerates providing medical care." – *C.M. Hocker Jr., M.D.*

"Physicians will regain control of the market through physician organizations." – *Steven Isenberg, M.D.*

"I really see a lot of regular people falling through the cracks in medicine."– *Tom Millikan, M.D.*

"Preventive medicine will be the dominant theme in the next ten years." – *Thomas Ringenberg, D.O.*

"We're going to have about a 25-year problem with the public and the politicians understanding how to run medicine, but I think medicine will hold out, even the solo practitioner." – *Sjoerd Roggeveen, M.D.*

"I'll be busier." – *Grace Lee Walker, M.D.*

"I wonder if medicine isn't getting too digital." – *Wayne White, M.D.* ❑

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New Medicaid laws bring regulatory relief

Mike Abrams
ISMA Director of Government Relations

Indiana legislators have given some relief to physicians frustrated by burdensome Medicaid regulations. The 1996 Indiana General Assembly enacted two bills that should solve some of the problems plaguing physicians and other health care providers involved in the Medicaid program.

During this year's 30-day short session, legislators also passed other bills of particular importance to physicians. These bills dealt with topics including maternity length of stay, domestic violence insurance discrimination, liability for jail physicians and "gag rule" prohibition. Another bill of interest to physicians establishes a committee to study managed care issues.

The 1996 Indiana General Assembly enacted two bills that should solve some of the problems plaguing physicians and other health care providers involved in the Medicaid program.

Medicaid relief

House Bill 1219 requires the Office of Medicaid Policy and Planning (OMPP) to submit any implementation plan for block grants to the legislative Joint Select Committee on Medicaid Reimbursement. This bill was introduced by Rep. Jeff Linder (R-Waldron) in anticipation of the federal government's taking some action turning Medicaid into block grants with wide state implementation authority. Linder wanted to make certain that Medicaid officials did not have unchecked authority to implement a Medicaid program with no legislative input. The joint select committee, chaired by Sen. Patricia Miller (R-Indianapolis), will have the opportunity to comment on any implementation scheme developed by the OMPP.

Senate Bill 175 allows the Medicaid agency to relax prior authorization requirements without going through the cumbersome rulemaking process. A major source of frustration with the Indiana Medicaid program has been the administration of prior authorization requirements. Busy phone lines, inappropriate responses to prior authorization requests and lengthy periods of being on "hold" have caused immeasurable difficulties in busy physician offices. Even some of those involved in administering the Medicaid program admit that some of the prior authorization requirements are unnecessary.

Senate Bill 175 also requires clean claims that are submitted electronically to be paid within 21 days. Clean claims submitted on paper must be paid within 30 days. If a clean claim is not paid by the statutory deadline, the bill requires interest to be paid to the provider. These provisions of the bill were requested in response to physicians' complaints about delays in the payment of clean Medicaid claims. Some physicians had even called ISMA to report that they were taking out loans in order to meet their payroll requirements because Medicaid was not paying clean claims.

Another bill addressing the administration of the Medicaid program, Senate Bill 442, was not enacted. Introduced by Sen. Steve Johnson (R-Kokomo), the bill sought to transfer the administration of the Medicaid program from the Family and Social Services Administration (FSSA) to the Indiana State Department of Health (ISDH). Although organized medicine generally supported the transfer, the ISMA did oppose two components of the bill. As introduced, the bill would have rescinded the requirement that the state health commissioner be a physician, and it would have turned the executive board of the ISDH into an advisory board rather than a policymaking board.

On its second reading in the Senate, Sen. Patricia Miller secured passage of an amendment restoring the requirement that the state health commissioner be a physician.

During conference committee action on the bill, Sen. Johnson

ordered a version of the bill that deleted the requirement that the health commissioner be a physician and caused the executive board to be advisory rather than policymaking. The ISMA worked to change both of those provisions and, eventually, a conference report was ordered that restored the requirement that the health commissioner be a physician. We were unable to convince the author of the necessity that the ISDH executive board remain a policymaking board, so ISMA's opposition continued.

Rep. Bill Crawford (D-Indianapolis), one of the four conferees assigned to the bill, agreed to withhold his signature on the conference report unless the executive board provision was changed. Since that change was not made, the lack of Rep. Crawford's signature precluded the bill from continuing through the legislative process.

This issue will almost certainly continue to be discussed in future legislative sessions.

Managed care to be studied

One of the most controversial health bills of the session was House Bill 1289. If the bill, initiated by the Indiana Dermatological Society, had passed in its original form, it would have allowed patients who are in gatekeeper plans to bypass the gatekeeper for dermatological and other specified services. However, the direct access bill, as it was known, did not pass in its original version. Instead, the bill that was enacted requires the managed care study committee to examine the issue, along with other aspects of managed care, including economic incentives present in capitated managed care plans, impact of managed care on patient satisfaction, standards and criteria used to select and de-select providers, and the impact of managed care on patient access to specialty care.

ISMA efforts successful

Besides Medicaid relief, several items of interest to Indiana physicians were enacted this session:

- Maternity length of stay: House Bill 1075 was supported by ISMA Resolution 95-8. As it was enacted, the bill requires insurance policies that cover maternity benefits to cover a length of stay that is consistent with guidelines adopted by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. The bill, which does not specify in the law the exact number of hours that a person must stay in the hospital following a delivery, was opposed solely by the Indiana State Chamber of Commerce. Even representatives of the insurance industry stood up to voice support for the bill.
- Physician filing/signing birth certificates: Senate Bill 346 was introduced as a result of ISMA Resolution 95-9. This law requires that only an attending physician, a midwife or other person designated by the hospital medical staff and present at the birth may file a birth certificate.
- Domestic violence insurance discrimination: Senate Bill 306 was supported as a result of ISMA Resolution 95-44. This bill prohibits an insurer from denying, canceling, rating or refusing to renew a health insurance policy based on a person's status as a victim of abuse. Further, it prohibits insurers from considering domestic violence a pre-existing condition.
- Telemedicine licensure: House Bill 1294 was introduced as a result of ISMA Resolution 95-45 and initiated by the Indiana Roentgen Society. This bill requires out-of-state physicians who routinely practice medicine on patients in Indiana through electronic means to be licensed by the Indiana Medical Licensing Board.
- Liability for jail physicians: House Bill 1309 was introduced as a result of ISMA Resolution 95-48. This bill requires the attorney general to defend contract physicians who treat persons who are in the custody of the Department of Correction.
- "Gag rule" prohibition: Language to prohibit "gag rules" was inserted into Senate Bill 392 at the request of the ISMA. As enacted, this law will prohibit insurance companies from limiting physicians in what they are permitted to tell their patients regarding treatment options.

'Christmas tree' bill vetoed

House Bill 1280 became somewhat of a legislative Christmas tree during the final hours of the legislative session. Three of the tree's "ornaments," AIDS, syphilis and violence, were a result of ISMA resolutions:

- ISMA Resolution 95-4: This language requires physicians to counsel pregnant women as to the advisability of an HIV

test, and to offer an HIV test to all pregnant women.

- ISMA Resolution 95-24: This language repeals the statutory requirement that all pregnant women be tested for syphilis during the third trimester. The new law will retain the requirement for a syphilis test during the first trimester, and states that a third trimester test must be conducted only if the pregnant woman belongs to a high risk population for which the CDC recommends a third trimester syphilis test.
- ISMA Resolution 95-40: This language enhances the criminal penalty assigned to persons convicted of assaulting/battering a health worker while the worker is performing his/her duties.

House Bill 1280 was vetoed by Gov. Evan Bayh because of concerns with language dealing with nursing homes. The section of the bill objectionable to the governor sought to extend the "certificate of need" law, which prohibits an increase in the number of nursing home beds in a community unless certain conditions are present. However, the governor's veto may be overridden during a veto-override session day that is scheduled to be held in May.

Offense, defense

We often measure the success of a legislative session in terms of what bills passed against our opposition. The 1996 legislature did not deliver any legislation that the ISMA vehemently opposed – the Indiana Compensation Act for Patients (INCAP) is intact, and there were no big efforts to repeal the "any willing provider" act.

Legislators leaving

The 1996 elections could have a dramatic impact on health care issues in the Indiana General Assembly. At least four senators will not be returning. Sen. Dick Thompson (R-North Salem) is leaving to run for the U.S. Congress seat being vacated by U.S. Rep. John Meyers. Sen. Jean Leising (R-Oldenburg) is leaving to run against U.S. Rep. Lee Hamilton. Sen. Doug Hunt (D-South Bend) and Sen. John Sinks (R-Fort Wayne) have chosen not to run for re-election.

Two state senators who are not up for re-election until 1998 are running for U.S. Congressional seats: Sen. Bob Hellmann (D-Terre Haute), the Senate minority leader, is running for the seat being vacated by U.S. Rep. John Meyers, and Sen. Joe Zakas (R-Granger) is running in the seat that is currently held by U.S. Rep. Tim Roemer.

Six members of the Indiana House of Representatives are not running for re-election. Rep. Steve Robbins (R-Connersville), Rep. Don Hume (D-Winslow), Rep. Jeff Hays (D-Evansville), and Rep. Jim Conlon (R-Crown Point) have all chosen not to run for re-election. Two incumbent state representatives are leaving the legislature to run for U.S. Congress: Rep. Kathy Willing (R-Lebanon) is running for the seat being vacated by Rep. John Meyers, and Rep. Richard McConnell (D-Princeton) is running for the seat currently held by Rep. John Hostettler. ❑

Answers to your questions on Medicaid managed care

Although Medicaid managed care has been in effect in parts of Indiana for almost two years, physicians still raise many questions about the program. The questions and concerns probably will increase this year, since on July 1 the 77 remaining counties join the 15 counties already participating in Hoosier Healthwise, as the managed care program is known.

The program has two components. Primary Care Case Management (PCCM) is the managed care program administered by the state of Indiana's Office of Medicaid Policy and Planning. The Risk Based Managed Care (RBMC) program is administered by two managed care organizations (MCOs), Healthsource Indiana and Maxicare. Healthsource Indiana covers all three regions of the state (northern, central and southern) through its program called CareWise. Maxicare, which covers the northern and southern regions, calls its Medicaid network MaxiHealth.

MaxiHealth has subcontracted to SIHO for the counties of Bartholomew, Brown, Clark, Crawford, Dearborn, Decatur, Floyd, Franklin, Harrison, Jackson, Jefferson, Jennings, Lawrence, Monroe, Ohio, Orange, Perry, Ripley, Scott, Switzerland and Washington. In northern Indiana, MaxiHealth has been subcontracted to Managed Health Services in the counties of Adams, Allen, Cass, DeKalb, Elkhart, Fulton, Huntington, Jasper, Kosciusko, LaGrange, Lake, LaPorte, Marshall, Miami, Newton, Noble, Porter, Pulaski, St. Joseph, Starke, Steuben, Wabash, Wells, White and Whitley.

To help physicians better understand the program, the ISMA practice management consultants have prepared a list of the most often asked questions and answers about Hoosier Healthwise.

Q. Who is eligible for Hoosier Healthwise?

A. The managed care programs are mandatory for all parents and children receiving cash assistance through Aid to Families with Dependent Children (AFDC) as well as non-AFDC pregnant women and children with incomes at or just above the poverty level (AFDC-related). Medicaid recipients not included in the managed care program are classified as wards of the court/foster care, blind/disabled, and the aged.

Q. Who can be a provider in the program?

A. A physician first must be a Medicaid provider. The physician also must sign a contract with one of the MCOs (managed care organizations) or an addendum to the Medicaid provider agreement.

Specialists must sign contracts with the MCOs to be in the RBMC delivery system. Specialists do not have additional contract requirements to be a part of the PCCM.

Q. Who can be a Primary Medical Provider (PMP)?

A. The PMP must be a physician in general practice, family practice, general pediatrics, general internal medicine or obstetrics/gynecology. Physicians enrolled in Medicaid as an internal medicine/ pediatrics specialist may enroll upon submitting documentation of their training in both internal medicine and pediatrics.

Healthsource and SIHO (the subcontractor for many southern Indiana counties) will allow a physician specializing in obstetrics/gynecology to participate as a specialist. SIHO will allow an obstetrician/gynecologist in a rural area to request a minimum of 50 patients.

Q. What are the responsibilities of the PMP?

A. The PMP agrees to be available to see patients a minimum of 20 hours per week, over at least three days at each practice. Clinics or group practices may fill this 20-hour, three-day-per-week requirement with more than one PMP.

The PMP must agree to accept a panel of not less than 150 nor more than 2,000 patients. The PMP cannot simply keep his or her current Medicaid patients, but must agree to accept at least 150 Hoosier Healthwise patients. There are no panel limits for specialists.

The PMP must be available by telephone 24 hours a day, seven days a week. Physicians may use a 24-hour telephone service that can be answered by the PMP, a designee such as an on-call physician, an answering service or a pager system. The PMP or another physician must be available to provide medically necessary services. The covering physician must be a Medicaid provider; however, this physician does not need to be a PMP.

The PMP is responsible for providing or authorizing most primary and preventive care services. These include but are not limited to:

- physician services;
- hospital inpatient and outpatient services; and
- ancillary services, including laboratory, radiology, orthotics, prosthetics, Early Periodic Screening Diagnosis and Treatment (EPSDT)/HealthWatch, audiology, durable medical equipment and supplies and home health services.

Another PMP responsibility is to submit non-reimbursable claims for missed appointments.

The PMP must adhere to universally accepted standards of preventive care for pregnant women, infants, children, adolescents and adults. Standards are written in the Hoosier Healthwise Provider Manual.

Q. Do I have to join Hoosier Healthwise?

A. No, you do not. You may continue to provide services to non-Hoosier Healthwise recipients. If you have a large number of patients who are AFDC or AFDC-related, you would not be able to continue to provide care for those patients. The program is mandatory for AFDC and AFDC-related recipients.

Q. When will a contract to join Hoosier Healthwise be presented?

A. Contracts can be signed anytime from now until July. You will probably be sent information in the mail or be asked to attend an educational meeting by Medicus (the company contracted by the OMPP to assist in implementing and administering Hoosier Healthwise) or one or both of the managed care companies before July. The networks will be forming during the entire year.

If you decide you definitely want to participate, the earlier the contracts are signed, the quicker you will be on the participating provider list. Your patients can choose you as their physician. If you wait to join, then your current patients could be auto-assigned to another physician because you are not part of the program when the patient must make the decision.

Andrew Johnston, president of Managed Health Services Indiana, offers the following suggestion to physicians: "My strong recommendation to all providers in third-year counties is to select some organization to work with, either PCCM, MaxiHealth or CareWise, and try to get your patients voluntarily enrolled before the program becomes mandatory. The initial auto-assign process does not consider the physician-patient relationship and interrupts continuity of care, and it is burdensome to obtain modifications of assignments."

Q. If a physician does not sign a contract, what happens to his or her Medicaid patients?

A. If the physician is in primary care, his or her AFDC and AFDC-related Medicaid patients are assigned to other physicians in the program. This program does not affect the elderly or disabled.

Q. How are Medicaid patients assigned to a managed care network?

A. Patients choose a physician, thereby becoming members of the physician's network. The three plans (PCCM, MaxiHealth and CareWise) are to be invisible to the patients.

Q. What if a physician does not sign up for any of the Hoosier Healthwise programs now but changes his or her mind in the future?

A. A physician may join the program at any time.

Q. Can a physician enroll in both PCCM and RBMC networks?

A. Yes, a primary care physician can enroll in both, but the process of accepting new patients is limited to one system of care at a time. In other words, PMPs participating in both PCCM and RBMC must designate under which system of care they wish to receive new patients, and this selection must be maintained for at least one calendar quarter. You may change systems effective on Jan. 1, April 1, July 1 or Oct. 1. Realistically, to change networks, you should plan to give 45 days' notice. If this is the first time you have contracted with the MCO, the contract must be in place and the process can take from 30 to 45 days. Notification is sent to the MCO on an open enrollment change form. It is possible to change every quarter, but not encouraged.

Specialists may participate in both PCCM and RBMC at the same time.

Q. What can a patient do if he is assigned to one physician but prefers to see another physician?

A. Recipients can call the Hoosier Healthwise Hotline and request a change in physicians. The process should take no more

than 45 days. Recipients can change PMPs once every six months, but they are encouraged to first discuss these reasons with their current PMP.

Q. Can a physician ever disenroll?

A. The participation contract is a binding agreement. To disenroll from Hoosier Healthwise, the physician should submit written notification for disenrollment, documenting the reasons prompting this decision. All requests concerning disenrollment from the RBMC system should be forwarded to the appropriate MCO. Requests to disenroll from the PCCM system should be sent to the Hoosier Healthwise program. The panel is put on hold while the request is reviewed. If the request is approved, the OMPP or the MCO will contact the PMP to initiate the disenrollment process. The physician must continue to act as the PMP for assigned patients for up to 45 days following disenrollment approval or until patients assigned to the physician choose a new PMP.

Q. What type of restrictions does the RBMC have?

A. Both Healthsource and Maxicare operate their companies along the guidelines of their regular managed care contracts. This places limitations on referrals and where the patient may go for prescriptions, laboratory services and hospitals.

Q. What are the fee schedules for PCCM and RBMC?

A. PCCM claims are paid based upon the Medicaid fee schedule. The PMP also receives a $3-per-patient month for care management services. This is automatically sent to the PMP. The specialist receives fee for service.

The MCOs will negotiate a fee schedule for participating providers. The fee schedule range will be anywhere from fee for service to fully capitated. At this time, the usual contract will be written with very little risk for the physician.

CareWise is introducing some new pricing methodology. The PMP can choose one of two payment methodologies:

- the Medicaid fee schedule plus $3 per member per month; or
- a bonus system in which the PMP participates in a reward sharing program if certain criteria are met within a specified time frame.

CareWise pays specialists fee for service based upon the Medicaid RBRVS fee schedule. In an effort to get obstetrician/gynecologists to participate as a specialist instead of PMPs, a global fee for a pregnancy is paid.

MaxiHealth generally will pay a PMP not participating in EPSDT the Medicaid RBRVS at the date of service plus 2%. If the PMP participates in EPSDT, the fee schedule is RBRVS plus $3 per member per month. Specialists receive Medicaid RBRVS at the date of service plus 1%. Maxicare will pay for out-of-network referrals to specialists.

SIHO/MaxiHealth reimburses the PMP either Medicaid RBRVS rates 2% if the physician does not do EPSDT or Medicaid RBRVS plus $3 per member per month if EPSDT is done. Specialty care is reimbursed at the Medicaid RBRVS rate plus 1%.

MaxiHealth/Managed Health Services will negotiate a capitation rate with the primary care physician for the services they provide directly and for outpatient use of the emergency room. Payments are based on Medicaid eligibility categories, and children are paid based on age. If no capitation rate is negotiated, fees are paid to contracting providers on the basis of the Medicaid fee schedule plus 1%.

Q. How are physicians paid for emergency department services?

A. All programs will pay a triage or screening fee to the physician for federally required medical screening examinations performed in the hospital emergency department. One of the program goals is to educate patients that the emergency department is not the place to obtain regular or non-emergency medical treatment. RBMC companies are not required to pay a triage fee to out-of-network physicians for non-emergent care.

PCCM covers emergent care without referral. A list of diagnoses considered emergent is available. Urgent services require a referral by the PMP. Care for routine conditions in the emergency department will not be reimbursed.

CareWise requires the PMP to authorize non-life-threatening services provided in the emergency department. The authorization must be given before the emergency visit. Documentation for these emergency visits will be reviewed on a case-by-case basis.

MaxiHealth will pay for urgent and emergent care according to set protocols. All emergency claims must be submitted on paper and are manually reviewed. For non-urgent care, the PMP must be

contacted for authorization or the claim will be denied.

SIHO/MaxiHealth requires the PMP to evaluate the severity of the patient's symptoms and triage the patient to the appropriate site for care, either the emergency department, next day appointment for non-urgent care or an urgent care center. After normal business hours, the SIHO Member Hotline will be staffed with a triage staff person to assist patients with seeking medically appropriate care.

MaxiHealth/Managed Health Services requires referrals except in cases where an agreement has been reached with a local hospital emergency department to provide primary care call coverage for a physician without prior authorization at rates that have been approved by MHS as comparable to the cost of providing care in the primary care physician's office. Where authorization is required, the physician may call an 800 number and make the authorization over the phone without having to complete the referral form. A referral form will be generated by MHS and forwarded to the PMP's office for verification.

Q. Will electronic filing of claims be required under PCCM or RBMC?

A. No, claims do not have to be filed electronically. The MCOs do not accept electronic claims at this time.

Q. If a physician enrolls in both a PCCM and an RBMC program, do charges have to be filed with both networks?

A. Yes, claims must be filed with the individual company.

Q. What happens if the managed care companies become financially insolvent?

A. The RBMC companies were investigated for financial solvency before the letting of contracts. Every company offered a contract was found to be financially sound. The contracts contain language that protect Medicaid physicians if the managed care companies should become insolvent.

Q. Who can I call for more information?

A. The Indiana State Medical Association practice management consultants are available to answer your questions. Call Meg Patton, Barbara Walker or Shelly Symmes at 1-800-257-4762 or (317) 261-2060.

You may also call the following sources:

- Hoosier Healthwise Hotline (PCCM): 1-800-889-9949.
- Healthsource (CareWise): 1-800-933-3466.
- Maxicare (MaxiHealth): southern region, 1-800-360-6294; northern region, 1-800-414-9475.
- SIHO/MaxiHealth: (812) 378-7000.
- MaxiHealth/Managed Health Services: (219) 756-7134 or 1-800-414-5946. ❑

Statewide medical education in Indiana

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Indianapolis

In the early 1960s, a newspaper reporter asked John D. VanNuys, M.D., dean of the Indiana University School of Medicine, why it was so difficult to recruit psychiatrists for positions in Indiana's mental health care institutions. Dr. VanNuys responded that Indiana's stringent medical licensure laws were restrictive, and Indiana, like the rest of the nation, suffered from a doctor shortage. There followed a decade of intense interest and activity throughout Indiana by multiple institutions and groups seeking to define the problem and to recommend solutions. All of this was played out against a background of the introduction of Medicare and Medicaid (1965-66) and the turmoil of the Vietnam War years (1965-74).

Indiana, like many other states, had a shortage of physicians complicated by an imbalance by specialty and geographic maldistribution. There was a general migration of physicians and professional and technical personnel from the Midwest. The state also ranked below the national average in numbers of dentists, nurses, lawyers and highly trained technical and engineering personnel. This highly publicized phenomenon was called the "Midwest Brain Drain."

Widespread concern about the "doctor shortage" spawned statewide interest in expanding the number of entering medical students as a strategy to address the shortfall of physicians. Numerous institutions of higher education, professional societies and community organizations developed proposals for additional medical schools in Indiana. In February 1964, Indiana University, at the request of Gov. Matthew E. Welsh, arranged for the Booz Allen & Hamilton Management Consultant Firm of Chicago to conduct a study as to how Indiana could meet the future needs for:

- "Medical education - How an increasing number of young men and women who wish to enter the field of medicine can be provided with the professional education they require.
- Practicing physicians - How medical education programs within the state can help ensure that a sufficient number of physicians will be available to provide the medical care needed by Indiana's growing population."

The study, conducted in two phases, culminated in a report submitted to Gov. Welsh in December 1964. The future needs, criteria and alternatives set forth in the final report were felt to "reflect the thinking of state government, university, medical and community leaders." In the list of 11 criteria that should be met as medical programs are expanded in Indiana, the number one criterion was: "First priority should be given to preparing the present Indiana University School of Medicine to meet existing obligations and improve the quality of existing programs." The Booz Allen & Hamilton report recommended a four-phased plan to be carried out in Indiana. Phase I, to be completed by 1968-69, called for "a substantial increase in state financial support to increase the faculty and facilities of the present School of Medicine and, with assistance from Indiana University, to improve and expand internships and residencies in community hospitals in Indiana. Also, it recommended that medical licensure laws be revised to facilitate entry of qualified physicians into Indiana from other states. During Phase I, Indiana University School of Medicine should reorganize internally to prepare for Phase II and strengthen the combined degree program in Bloomington."

Phase II, expected to last from 1968-69 to 1974-75, projected "that medical school enrollments in the state will need to about double in the next ten years and that Indiana will need to retain or attract about the same number of physicians that might be graduated from such expanded enrollments if it is only to maintain the present proportion of physicians to the population. There are many alternative approaches to meeting the needs for expansion of undergraduate medical education facilities in the state. The plan recommended in Phase II is to expand Indiana University School of Medicine on the present campus, but in smaller organization units. Such an approach would combine the opportunities and economics of a larger medical school with the effectiveness of a smaller school. In the second phase, therefore, enrollments would expand by about 50% under this new, but promising, approach to medical education and the needs of the

state. During this phase, considerable progress toward the development of a 'medical university' should be possible."

Phase III, 1974-75 to 1978-79, envisioned enrollments in medical school would double in Indiana to 400 entering students.

Phase IV, beginning sometime after 1980, anticipated a re-examination of needs, criteria and alternatives.

Booz Allen & Hamilton detailed six alternative means for meeting future needs for medical education in Indiana. The alternatives ranged from doing nothing to expanding the IU School of Medicine, to establishing another four-year medical school in Bloomington, Evansville, Fort Wayne, Lake County, South Bend-Mishawaka-Elkhart, Ball State University, Indiana State University, Purdue University, University of Notre Dame and/or to one or more two-year basic science medical schools on selected campuses in Indiana. No further action on the Booz Allen & Hamilton report was forthcoming.

The faculty of the IU School of Medicine had elected not to accept a passive role in the innovation of medical education. It fully expected to be counted in the forefront of American schools interested in new and better methods of quality medical education. A committee appointed by Dr. VanNuys in 1962 and headed by John I. Nurnberger, M.D., began a study of the school's traditional "lockstep" curriculum and started the process to design a new curriculum. In 1964, Dr. Nurnberger, acting dean of the IU School of Medicine, expanded the committee to a Clinical Council for Curricular Affairs with William P. Deiss, M.D., then professor of medicine and biochemistry, as chairman. The council's important studies were continued by successive expanded committees appointed by Dean Glenn W. Irwin Jr., M.D., until the entire medical school faculty was involved in some way. In 1966, Edward Tyler, M.D., became co-chairman with Dr. Deiss, and by January 1968, the initial major innovation, the "Introduction to Medicine" course was presented for the first time in the new and evolving curriculum. Statewide clinical electives were arranged and offered to fourth year students in 1969. Projections called for full implementation in 1971 of the 1966 faculty-approved "Ultimate Curriculum."

During the 1965 session of the Indiana General Assembly, Senate Bill 336 proposed an act to establish a college of medicine with a department of community medicine and family practice at what was then called Ball State Teacher's College. It was not enacted.

In May 1965, Dr. Irwin, dean of the IU School of Medicine, appointed a committee of the medical school faculty to coordinate the various studies relating to developing the best possible plan, from the point of view of the state as a whole, for future medical education in Indiana. This 10-member committee of the faculty chaired by George T. Lukemeyer, M.D., made its report in June 1966. Several problems existed in the state. The number of doctors for every 100,000 people in Indiana was lower (97 per 100,000) than any neighboring state except Kentucky and substantially below the national average of 143 per 100,000. In 1965, Indiana had 2.5% of the U.S. population, and also had 2.5% of the nation's first-year medical students (216). In 1965, Indiana's one medical school produced more graduates than the total number of internships in all of the hospitals in the state. Indiana was a "brain-drain" state in which only 51% of the doctors educated in Indiana stayed to practice in the state. The one school of medicine was considerably underfunded. There were too few directors of medical education in Indiana hospitals. Indiana's licensure laws were restrictive and discouraged qualified physicians from coming to Indiana.

Indiana was a "brain-drain" state in which only 51% of the doctors educated in Indiana stayed to practice in the state.

In the years preceding the 1966 Lukemeyer Committee Report, the IU School of Medicine had taken several steps to help alleviate the doctor shortage. The number of medical students accepted and graduated had been increased rapidly. (There were 150 matriculants in 1950, 202 in 1964 and 216 in 1966.) This rate of increase of freshman medical student enrollment at the IU School of Medicine far exceeded the rate for the rest of

the nation and was much greater than the rate of population increase in the state from 1950 to 1966. Further, a rapid expansion of the residency and fellowship training program at the IU Medical Center was in progress. From 67 residents at the IU Medical Center in 1950, there were nearly 300 in 1966. Allied Health Science training programs had been continuously increased. The innovative combined degree (M.D.-Ph.D.) medical education program was initiated by the medical school on the Bloomington campus in 1959.

The 1966 Lukemeyer Committee Report made several recommendations. First, the IU School of Medicine needed adequate support. Graduate (internship and residency) medical education needed to be expanded to the community hospitals throughout the state. There needed to be a statewide communications network using telephone, television and computer linkage connecting participating colleges and universities, cooperating community hospitals and the IU Medical Center. The committee endorsed the new and evolving curriculum for the medical school, which presented a core of preclinical education in a single first year. The second year included a new introduction to clinical medicine transitional course, and the third year advanced education in both basic and clinical sciences. The fourth year was envisioned as an elective year with many opportunities for senior clinical experiences in community hospitals throughout Indiana. The school of medicine should give appropriate academic titles to full-time directors of medical education throughout the state as well as help fund these positions.

Partial funding of internship and residency programs from the state via the medical school should be accomplished. Expansion of the medical library via a statewide electronic link-up with participating institutions and physicians should be developed. The first part of the core curriculum, the basic science year, could be taken at any university or college with strong basic science departments that were organized, staffed and equipped to do the work. Such a model had existed on the Bloomington campus since 1959.

This Indiana University plan could be quickly implemented and would directly approach the problem of the physician brain drain in the state. It would also be much less expensive than building a new four-year medical school and teaching hospital. The new curriculum would permit a future increase in entering students at other universities in the state. By increasing and filling good and attractive internship and residency programs, the state would retain more doctors.

This then was the Indiana plan as presented in April 1966 to the Subcommittee to Study Medical Education of the Legislative Advisory Commission of the 94th Indiana General Assembly. The proposal was met with the usual amount of skepticism, derision and, in some instances, open hostility. The plan had not been concocted as a revolutionary approach to medical education in Indiana. It resulted from a very fortunate set of geographic, demographic and educational circumstances.

The 1967 General Assembly presented real challenges to Dean Irwin and Claude Rich, Indiana University legislative liaison, as the Indiana University Plan for Statewide Medical Education moved through the 61-day legislative process. There was another movement by presidents and directors of medical education in the larger hospitals throughout the state to obtain state support for the financing of internship-residency programs. The cost of medical education conducted by private hospitals was a source of increasing apprehension.

The following year, 1967, the Indiana General Assembly enacted unanimously Senate Enrolled Act 359 into law. This unique law emphasized the state's desire and willingness to support medical education in Indiana and included some of the elements of the Indiana University plan. The introduction to the law reads as follows: "An act providing for the establishment of a regional, hospital affiliated, internship-residency program and development of an expanded continuing medical education program; and making an appropriation therefore."

The legislation included two sections. The first made a $1 million appropriation to support the internship/residency programs throughout the state. A Medical Education Board of five members was established, with the dean of the IU School of Medicine as chairman. This board was authorized to establish policies for the use of expenditures for the internship/residency programs but was not to establish or recommend policies of teaching or education by the medical school. The Medical Education Board

established policies regarding the funding of stipend supplements for interns and residents throughout Indiana.

A second portion of the law appropriated $1.5 million dollars to be used by the IU School of Medicine for the appointment and funding of statewide off-campus faculty members, mostly at the community level, and for operating and purchasing equipment for a statewide communications system including library and computer facilities. A grant-in-aid program for community hospitals contributed to the support of off-campus directors of medical education, volunteer faculty members and the graduate medical education and continuing medical education programs in the hospitals.

This Phase I of a statewide medical education system was effective immediately. In 1967, just prior to the initiation of the program, there were 428 interns and residents in Indiana, and the vast majority were located only in two cities, Indianapolis and South Bend. Ten years later, there were 865 residents in nine Indiana cities with 27 participating hospitals. The percentage of IU School of Medicine graduates taking intern-resident training in the state increased dramatically, and the number of practicing physicians in Indiana rose steadily.

An important second phase of the Indiana program began in 1968 when it became obvious that even greater numbers of entering medical students were needed, even though the IU School of Medicine had continued its increase in enrollments. By 1967 there were 221 entering students at the IU School of Medicine. In September 1968, the medical school, in cooperation with Purdue and Notre Dame universities, embarked upon pilot programs for the teaching of basic medical sciences to a limited number of medical students in Lafayette and South Bend. Entering medical students in 1968 could be found at Indiana University in Bloomington, IU School of Medicine in Indianapolis, Purdue University in Lafayette and the University of Notre Dame in South Bend. The medical school had had considerable experience in this area because in 1959 a medical education program was established at Indiana University in Bloomington that offered the basic medical sciences to undergraduate, medical and graduate students. The Bloomington program proved that basic medical sciences could be provided at a strong university that had good divisions of biological and physical sciences, even though that institution did not have a traditional four-year medical school on its campus.

An important second phase of the Indiana program began in 1968 when it became obvious that even greater numbers of entering medical students were needed ...

Another study of medical education in Indiana was undertaken by the State Policy Commission on Post High School Education established by the 1967 Indiana General Assembly. This commission, chaired by Richard D. Stoner, made its report to Gov. Roger D. Branigin in December 1968. The commission made 17 recommendations, including the establishment of a statewide planning and coordinating board of regents. The proposed board of regents should establish and appoint an advisory council on education for the health professions. The commission recommended the continuation of the new IU Statewide Internship-Residency Program until evaluated by the proposed advisory council. The section of this report on the education for the health professions again cited the shortage of physicians in the state. Indiana ranked 35th in the number of physicians per population among the 50 states. Although the IU School of Medicine was the largest school in enrollment in the United States (221 entering students in 1967-68), Indiana ranked 21st in the number of medical students per 100,000 population. The Stoner Commission Report reaffirmed the deficiencies in the number and quality of internship opportunities in the state. It documented that a significant number of the available residency positions in Indiana were unfilled. It emphasized again that the decision for the location of practice of a physician is largely dependent upon where he/she interns or does

a residency rather than where one graduates from medical school. This report considered the new statewide internship-residency program in Indiana a truly significant development.

The Stoner Commission Report concluded that expansion of medical student education in Indiana was urgent. Four possible alternatives that were considered included:

1. Further expansion of the IU Medical Center;
2. The establishment of a two-year medical school;
3. The establishment of a new four-year medical school; and
4. Integration of senior universities in a statewide system of medical education.

The final decision regarding expansion of medical education was to be the responsibility of the proposed board of regents assisted by the proposed advisory council on education for the health professions.

Beurt SerVaas, a member of the Stoner Commission, prepared an appendix to the report. He proposed an integration of senior universities in a statewide system of medical education. This proposal was similar to the Indiana University Plan for Future Medical Education in Indiana, which was announced in 1966 and had partially been tested when first-year medical students were admitted to Purdue University in Lafayette and to Notre Dame for the 1968-69 year.

Creation of the Commission on Medical Education

By executive order on June 12, 1969, Gov. Edgar D. Whitcomb established a Commission on Medical Education and charged the commission to devise and implement a system of statewide medical education that could immediately and effectively increase the number of physicians in training while at the same time maintaining medicine's high academic standards.

The governor's commission was composed of 32 members, approximately one-third of whom were M.D.s, with the majority representing the lay consumer of medical services, representative legislators from both political parties, the academic vice presidents of Indiana's major universities, scientists, educators, hospital administrators and businessmen, together with the dean of the IU School of Medicine and the presidents of the junior and senior classes of the medical school.

Under the chairmanship of Indianapolis businessman Beurt R. SerVaas, the commission considered a number of proposed plans to meet the need for new physicians. On Feb. 11, 1970, the commission adopted a resolution for a Statewide Medical Education Program. The resolution, in summary, stated that the IU medical school had expanded its enrollment to meet the need for more physicians in the state but finds it difficult to satisfy the ever-increasing demand for qualified persons to deliver health care services. The building of a traditional second medical school would require a delay of approximately 10 years before increasing the number of graduating physicians, would cost an amount exceeding the current financial capabilities of the state and would materially benefit only one limited area of the state.

The resolution adopted a "Seven Center Plan," creating medical education centers in the communities of Lake County, South Bend, Fort Wayne, Muncie, Lafayette, Terre Haute and Evansville for the year 1970-71. The administration of the IU School of Medicine was invested with the responsibility and authority for planning and implementing an orderly expansion program. Joint faculty appointments by the IU School of Medicine and other institutions of higher education should be made. The medical school would provide admission procedures, curricular development and accreditation. The establishment of a system of evaluation must be made to ensure continuing quality of the educational program.

The commission's resolution recognized that the acute needs for augmented physical facilities and additional faculty at the IU Medical Center in Indianapolis must simultaneously be met to ensure the continuing high quality of education to the increased number of students for the health care professions under this plan.

After the Commission on Medical Education adopted its resolution in February 1970, a series of well-planned meetings were scheduled in each of the seven communities where medical education centers were to be located. The following people attended and presented the case of the Indiana Statewide Medical Education Program: Gov. Edgar D. Whitcomb; Beurt R. SerVaas, chairman of the commission; Dr. Irwin, dean of the IU School of Medicine; and Steven C. Beering, M.D., associate dean. The following representatives attended the meetings in their communities: the

mayor, state legislators, commission members, media, university officials, health professionals and civic leaders. The meetings were well-attended and stimulated much good two-way discussion. Throughout the state, the plan seemed to have strong support.

The Indiana Statewide Medical Education system established by 1971 Indiana General Assembly

House Enrolled Act 1430 was overwhelmingly approved by the legislature in 1971. It endorsed the resolution of the Commission on Medical Education in which the administration of the IU School of Medicine shall be responsible for planning and implementing the orderly development and expansion of a medical education program in each center in cooperation with the director and staff of the cooperating institutions. $1,750,000 was authorized for the 1971-72 academic year to begin the program. By June 30, 1971, a director had been recruited for each of the seven centers for medical education.

Implementation of the Indiana Statewide Medical Education system began immediately after the 1971 legislative approval. Dr. Beering, associate dean, coordinated the overall implementation of the system. Dr. Lukemeyer, executive associate dean, supervised the programs of the Medical Educational Resources Program, the Indiana Higher Education Telecommunication System and the expansion of services by the medical school library. That year, the number of entering medical students was increased to 273. In 1972, 290 students were admitted, and all centers were assigned medical students, except Fort Wayne, which had elected to be a clinical program initially. In 1973, 305 students were admitted, and each center, except Fort Wayne, had 20 entering medical students. The Fort Wayne Center enrolled its first class of entering medical students in 1981. Total entering enrollment in the statewide medical educational program remained at 305 until 1982 and then was gradually decreased to 265 in 1986. The entering class size was again increased in 1992 to its current 280 students. By 1982, all centers had developed programs for second-year students.

In the three decades since the start of Phase I of the Indiana plan, the total number of interns and residents in Indiana hospitals increased from 428 in 1967 to 1,276 in 1995. Family practice residents in Indiana hospitals increased from 175 in 1977 to 258 in 1995. Fifteen hospitals in seven cities now conduct educational programs in the statewide residency program.

As we celebrate the 25th anniversary of the unique IU School of Medicine Statewide Medical Education program, some interesting statistics emerge. In 1970 there were 5,274 nonfederal physicians in Indiana for a 102-per-100,000 population ratio. In 1995, there were approximately 10,430 nonfederal physicians in Indiana, for a ratio of 190-per-100,000 population. In this 25-year period of the Indiana Statewide System of Medical Education, the number of physicians in Indiana has essentially doubled (98%). The population of the state, during the same period of time, has increased by approximately 8%.

Another important feature of the statewide system is the active participation of part-paid and volunteer faculty physicians throughout Indiana. In the 1994-95 academic year, the statewide system faculty included 956 full-time, 69 part-time and 1,896 volunteer members. This means more than 25% of Indiana physicians are teaching medical students and/or residents and colleagues in a remarkable decentralized program involving undergraduate, graduate and continuing medical education.

Council to study the future of the IU System of Statewide Medical Education

The 1991-93 IU School of Medicine budget was reduced drastically, and a $7 million deficit existed during the biennium for the Statewide System on Medical Education. As a last resort, consolidating or closing one or more of the seven centers was discussed. The seven center communities' reactions to this proposal were such that the Indiana legislature forbade closing any of the centers during 1991-92. Also, the General Assembly asked the IU School of Medicine to submit a report to the state budget committee by Nov. 1, 1991, covering the future of the Indiana Statewide System of Medical Education. To help prepare the response to the General Assembly's request, IU Vice President Gerald L. Bepko and Walter J. Daly, M.D., dean of the medical school, appointed a council with broad representation to conduct a study of the statewide medical education system. Geoffrey Segar, an Indianapolis attorney, chaired the council.

Members of the council heard testimony by appropriate groups

in support of each of the seven centers plus the medical sciences program at Bloomington. All of the communities agreed that the centers provided the following important contributions:

1. Attraction of physicians to the community;
2. Retention of physicians and improved quality of care;
3. Enhancement of the host institutions' programs; and
4. Favorable economic impact on the regions.

The report of the council concluded that the Indiana University Statewide Medical Education System has been shown to be fundamental to the health and prosperity of the people of the state. It has contributed to a doubling of the number of physicians in the state and partially redressing the geographic maldistribution of primary care physicians in the state. Both now, and in the foreseeable future, the health care delivery system will account for a significant portion of the expenditures affecting the economy and stability of the regions. The most important ingredient will be the adequate supply of well-trained physicians needed for the prevention and treatment of disease and care for an ever-widening range of health disorders. The centers are a vital part of the system and contributed effectively to the progress that has been documented. Testimony from the communities in which the centers are located underscore their importance to the region and the commitment of their leadership to assist in raising local support for capital expenses and urging their legislators to seek additional state appropriations.

The council unanimously recommended that all Indiana University Centers for Medical Education be continued and enhanced and that a primary care network be developed to attract resident physicians to primary care. The council urged the General Assembly to increase the level of funding for this important program.

With the introduction of the Indiana Statewide Medical Education Program, the traditional concept of an academic medical center as a discrete and isolated geographic entity was discarded. Indiana's statewide decentralized program, under the direction of the IU School of Medicine and in cooperation with other institutions of higher education, community hospitals and practicing physicians, made an immediate and lasting beneficial impact on the state's medical workforce and opportunities for participation in a continuum of high quality medical education programs embracing undergraduate, graduate and continuing medical education. ❑

Dr. Lukemeyer is professor emeritus, Indiana University School of Medicine, and chairman of the editorial board of Indiana Medicine. *Dr. Irwin is dean emeritus, Indiana University School of Medicine.*

Beware of retirement plan excise taxes

Joel M. Blau, CFP
Chicago

Use caution when taking retirement distributions from your tax qualified plans. The Tax Reform Act of 1986 established a 15% excise tax on withdrawals from retirement plans that exceed certain limits. To determine if you are affected, you must include the total value of all distributions from qualified pension and profit sharing plans, Keoghs, 403(b) tax sheltered annuities and IRAs. After tax employee contributions are not included in the calculation.

Generally, the 15% excise tax will apply to yearly distributions in excess of $155,000 for 1996. This figure can increase in the future as it is indexed for inflation. If you were to take a lump sum distribution, the excise tax will be on the amount in excess of five times the annual limit of $155,000 or $775,000. Keep in mind that the lump sum excise tax applies only to a taxable distribution, not to a qualified rollover. With a rollover, you actually transfer your qualified plan, typically at retirement or termination of employment, to an IRA. In this case, the excise tax will only apply when you begin taking taxable distributions from the IRA.

What makes matters more confusing is that some taxpayers used an irrevocable grandfather election on their 1987 or 1988 tax return. These individuals had accrued qualified retirement benefits in excess of $562,500 as of Aug. 1, 1986. The election allowed for a grandfathering of those benefits at the time and caused the portion of any distribution attributable to such accrued benefits to be exempt from the 15% excise tax.

A seemingly logical method of avoiding the excise tax altogether would be to simply limit your annual retirement distributions to the threshold amount. At death, your remaining balance would be distributed to your intended heirs. Unfortunately, the government was not about to allow taxpayers this generation skipping opportunity. If an individual dies before receiving his entire retirement benefit, an "excess retirement accumulation" tax may be imposed on that portion deemed to be excessive. To determine the amount to which the excise tax is imposed, a calculation is made. The 15% added tax is computed by taking the current value of all qualified retirement plans and subtracting the present of an annuity payable for the life expectancy of the individual immediately before his or her death. The annuity is based on annual $155,000 payments or the applicable annual figure if the grandfather election was made. To make matters worse, the excise tax at death is in addition to the federal estate tax, which has a top tax rate of 55%.

If the value of your retirement plan subjects you to the 15% excess distribution or accumulation excise tax, proper planning is needed. The use of various strategic estate and retirement planning techniques can help you minimize the effect of the excise tax over your lifetime, as well as at death. ❑

The author is president of MEDICUS Asset Advisors, Inc., an associate of AMA Investment Advisers, L.P. He welcomes readers' questions and can be reached at 1-800-883-8555.

Response of bidimensionally measurable metastases to flutamide withdrawal in a patient with advanced prostate cancer

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Androgen blockade is the primary therapeutic maneuver in patients with symptomatic, metastatic prostate cancer, and either surgical castration or the use of luteinizing hormone-releasing hormone (LHRH) agonists are felt to be equivalent in terms of response, time to progression and overall survival.[1] However, the data regarding the potential benefits of the addition of nonsteroidal antiandrogens such as flutamide (Eulexin®) or bicalutamide (Casodex®) to either bilateral orchiectomy or LHRH agonist are conflicting. While the most frequently cited study demonstrated a seven-month survival advantage for patients receiving combined androgen blockade,[2] a more recently published meta-analysis of 22 randomized trials involving over 5,700 patients failed to demonstrate any survival advantage for this approach.[3] Regardless of the approach taken, the median time to progression in patients with advanced prostate cancer treated with primary hormonal therapy remains approximately 18 months, with a median survival in such "hormone-refractory" patients of 12 months. Due to the lack of efficacy of second-line hormonal theapy in hormone-refractory patients and the limited benefits seen with systemic chemotherapy, there are few treatment options available in this clinical setting.

Despite their lack of proven efficacy, there is widespread use of the antiandrogens. A number of previous reports in the literature have documented serologic responses at the time of documented disease progression simply to the withdrawal of the antiandrogen, although only rarely have bidimensionally measurable lesions had documented regression. We describe below such a case and discuss the implications for this and similar cases on the interpretation of response to subsequent therapy, as well as its impact on clinical trial design.

Clinical case

The patient was a 70-year-old white man who was found on routine physical examination in October 1990 to have an asymmetrically enlarged prostate, and ultimately a transrectal biopsy revealed a moderately differentiated adenocarcinoma of the prostate. Staging workup included a normal bone scan and a normal abdominal/pelvic computerized tomographic (CT) scan. However, serologies were highly suggestive of extracapsular spread of the disease, with a serum prostate specific antigen (PSA) of 391 ng/mL (normal 0-4) and an enzymatic acid phosphatase of 11.1 ng/mL (normal 0-2). The patient was treated primarily with hormonal therapy beginning in December 1990, consisting of bilateral orchiectomy and flutamide at a standard dose of 250 mg orally three times daily. Following the initiation of hormonal treatment, the patient's serum PSA reached a nadir of 1.0 ng/mL.

The patient did well, but in January 1993 he experienced a rise in his serum PSA to a level of 142 ng/mL, further rising by July 1993 to 662 ng/mL. He became symptomatic from his progressive disease at that time with a 15-pound weight loss, abdominal fullness, lower back pain and symptoms of bladder outlet obstruction and was referred to Indiana University Medical Center.

Restaging included an abdominal/pelvic CT scan that revealed right hydronephrosis, extensive retroperitoneal adenopathy, a 2 X 2 cm mass in the head of the pancreas, and a 7 X 8 X 6 cm prostatic mass with extension into the base of the bladder *(Figure 1A)*. A chest CT scan also demonstrated metastatic disease, with large para-esophageal adenopathy *(Figure 1B)*. Therapeutic maneuvers included a transurethral resection of the prostate for relief of obstructive symptoms and discontinuation of flutamide in preparation for entry onto a clinical trial of chemotherapy.

The patient was restaged four weeks after discontinuation of flutamide. A serum PSA had decreased from 662 to 100 ng/mL. A marked reduction in the size of both his intra-abdominal *(Figure 2A)* and chest *(Figure 2B)* metastases was noted on repeat CT scans, including complete resolu-

tion of the 5-cm paraesophageal mass. This radiographic and serologic response was accompanied by symptomatic improvement of abdominal and back pain. The patient's serum PSA continued to decline to its nadir of 10.3 ng/mL 11 weeks following discontinuation of flutamide.

The patient's serum PSA began to rise 14 weeks after discontinuation of flutamide (54 ng/mL) and was associated with a return of systemic symptoms. Repeat CT scans demonstrated a marked increase in the size of all bidimensionally measurable lesions, as well as the appearance of new hepatic metastases. Chemotherapy with estramustine phosphate and vinblastine was initiated, but the patient failed to respond and succumbed to the disease in February 1994.

Discussion

The treatment options available in the setting of hormone-refractory prostate cancer are limited at best. Second-line hormonal therapy has no effect on the natural history of the disease. Recent "advances" in chemotherapy such as suramin, estramustine phosphate + vinblastine, and mitoxantrone + prednisone have documented increased response rates utilizing surrogate endpoints such as a 50% decline in PSA, although no improvement in overall survival has been demonstrated with any of these regimens.

The "flutamide withdrawal syndrome" was originally described by Kelly and Scher[4,5], who reported that 29% of patients progressing on combined androgen blockade had at least a 50% reduction in serum PSA following discontinuation of flutamide. They also reported a single patient with bidimensionally measurable disease who had an objective

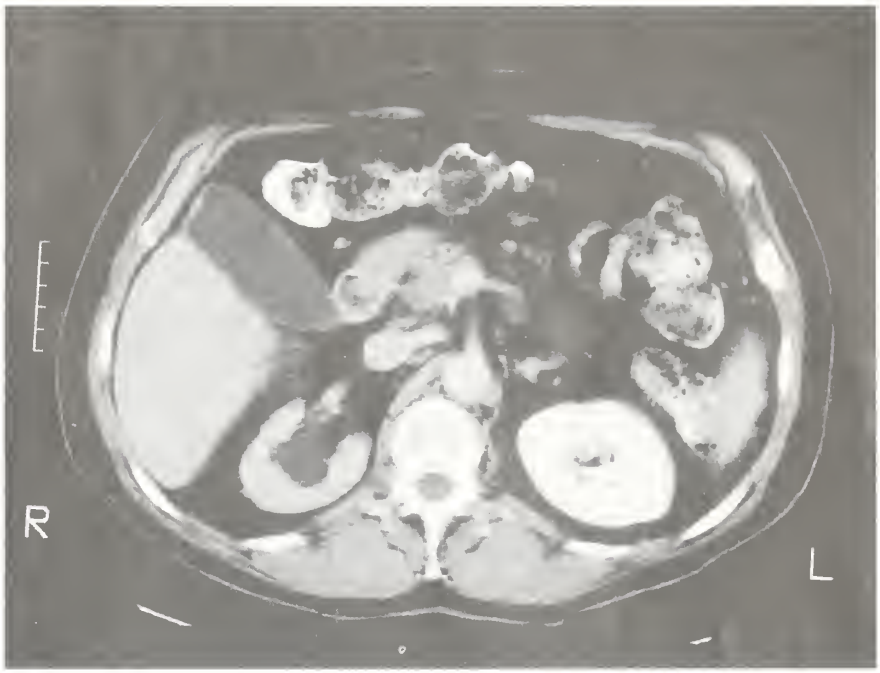

Figure 1A

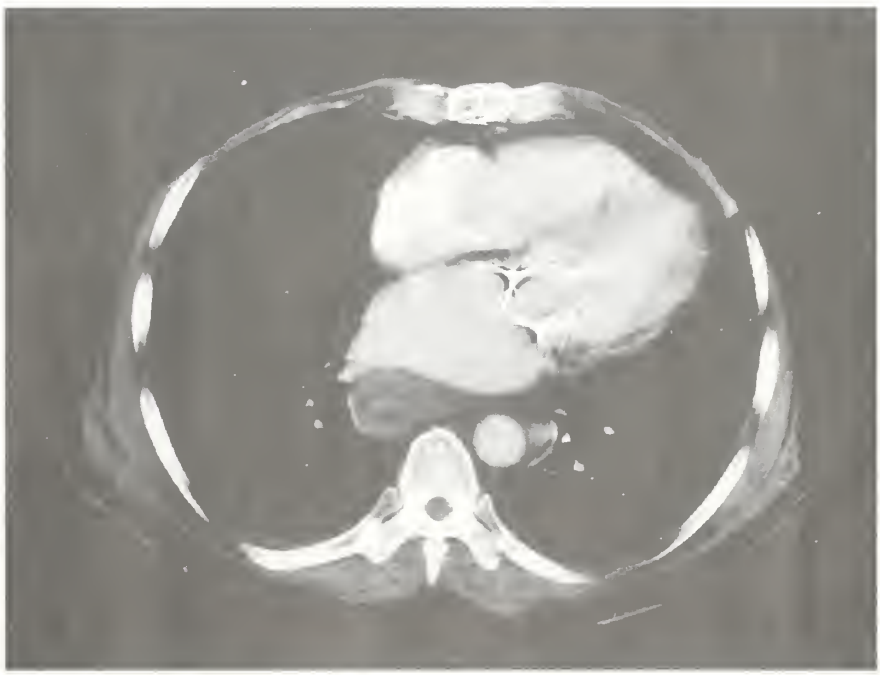

Figure 1B

Figure 1: Prior to flutamide withdrawal, demonstration of a 2 X 2 cm pancreatic mass and right hydronephrosis (1A) on abdominal CT scan, and a 5 cm paraesophageal soft tissue mass on chest CT scan (1 B).

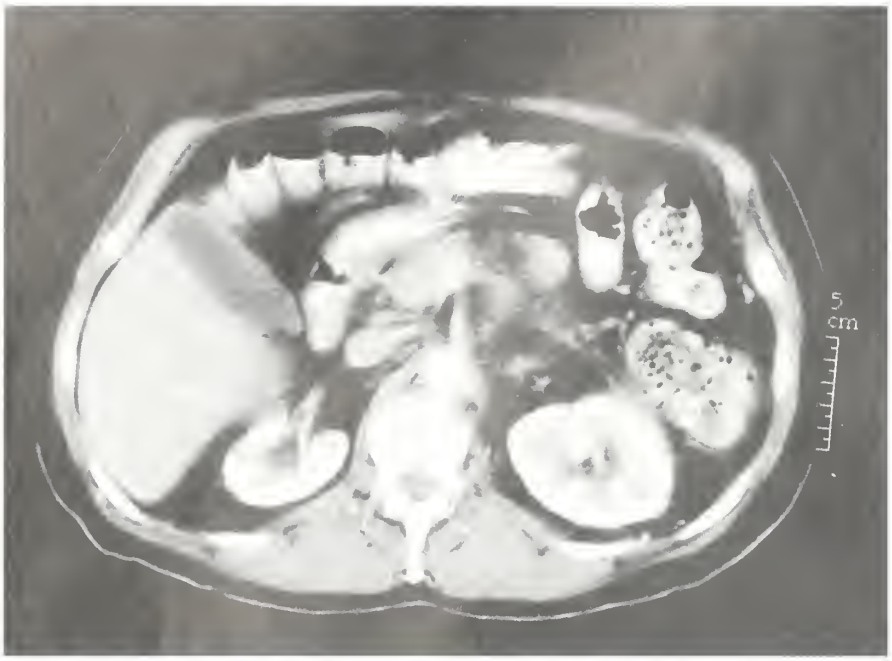

Figure 2A

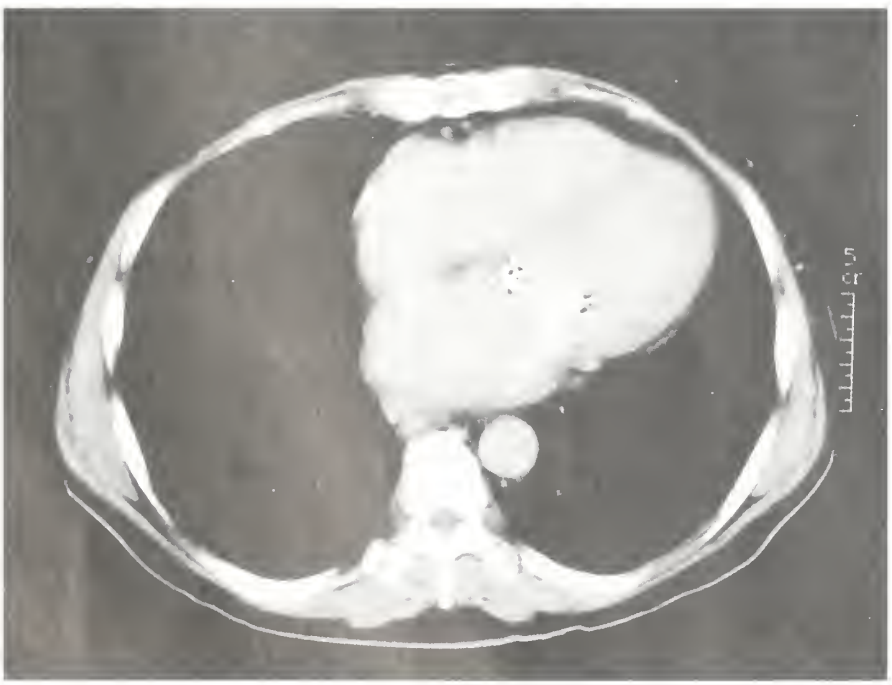

Figure 2B

Figure 2: Four weeks after discontinuation of flutamide, demonstrating resolution of right hydronephrosis (2A) secondary to decreased retroperitoneal adenopathy (not pictured), and complete resolution of the para-esophageal soft tissue mass (2B).

(>50% decrease) response to this withdrawal. These responses were associated with improvement in clinical symptoms, but were short-lived, with a median duration of response of 5+ months. Other investigators have reported response rates of 48% to 63% to flutamide withdrawal.[6,7] However, similar responses have been reported with the discontinuation of other agents with antiandrogen activity, including megestrol acetate,[8] bicalutamide,[9,10] or diethylstilbestrol,[11] and the syndrome is therefore more appropriately termed the "antiandrogen withdrawal syndrome."

The underlying pathophysiology that allows withdrawal of an antiandrogen to result in temporary tumor regressions in some patients with hormone-refractory prostate cancer remains undefined. There are a number of potential hypotheses, however, which parallel previous discussions of the potential mechanisms of tamoxifen withdrawal responses in breast cancer patients. One possibility is that tumor heterogeneity allows for a broad spectrum of sensitivity to circulating androgens. In such a system, low circulating levels of androgens could select for clones of tumor cells exquisitely sensitive to the growth-stimulatory effects of very low circulating levels of those androgens, and withdrawal of this stimulation might result in inhibition of the growth of those clones and a corresponding clinical response.[12]

A more likely explanation implicates a mutated androgen receptor for which antiandrogens binding results in a stimulatory response. Some clones of a human prostate cancer cell line (LNCaP) that demonstrate a single point mutation in the genetic sequence coding for the androgen receptor show increased binding of

progestogens and estradiol despite the lack of specific receptors for these agents.[13] *In vitro* stimulation of prostate cancer cell growth by hydroxyflutamide has been demonstrated,[14,15] and it is interesting to note that one human prostate cancer cell line that does not contain the androgen receptor does not exhibit gowth stimulation by hydroxyflutamide.

Regardless of the mechanism, withdrawal of an antiandrogen represents a reasonable therapeutic maneuver in patients treated with combined androgen blockade who have developed evidence of progressive disease. Although such responses are generally short-lived, this maneuver must precede other therapeutic interventions. The simultaneous cessation of an antiandrogen and initiation of other systemic therapy may result in the misinterpretation of the observed response as attributed to the subsequent therapy. A number of investigators have suggested that a number of the responses attributed to either second-line hormonal therapy or chemotherapy in the published literature are in fact antiandrogen withdrawal responses. Because of this possibility, ongoing chemotherapy clinical trials in hormone-refractory patients require discontinuation of an antiandrogen for a fixed amount of time and/or the demonstration of progressive disease following antiandrogen withdrawal. ❑

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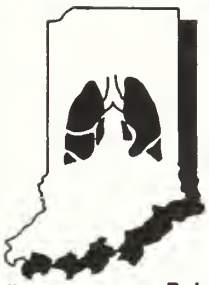

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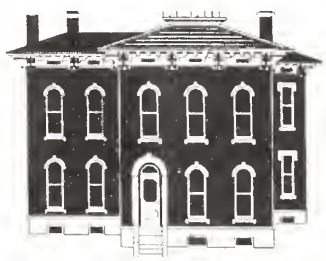

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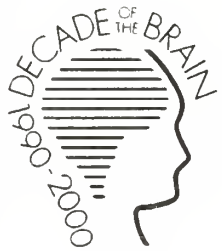

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ANATOMIC PATHOLOGY

physicians' directory

NEPHROLOGY

NEPHROLOGY

Indiana Nephrology & Internal Medicine P.C.

Indianapolis:

East
6635 E 21st Street, Ste 100
Indianapolis, IN 46219
317-353-8985
Ronald K Bloom, MD
Kevin J Lavelle, MD
Patsy Maikranz, MD
Rita A Markus, MD

North
8330 Naab Road, Ste 234
Indianapolis, IN 46260
317-875-0084
Kenneth W Beckley, MD
Tae-Kae Chong, MD
Jay H Weiss, MD
Joseph D Whelan, MD

South
1350 E County Line Rd, Ste L
Indianapolis, IN 46227
317-865-8530
Douglas R Maxwell, MD

Kokomo:
2302 S Dixon Road, Ste 150
Kokomo, IN 46902
317-453-1205
Dawn M Sabau, MD

Richmond:
1010 North J Street
Richmond, IN 47374
317-962-4735
K N Venkat, MD
(June 1996)

IN & IM

NEPHROLOGY

OUTPATIENT DIALYSIS

Indiana Nephrology & Internal Medicine
Affiliated Dialysis Centers

Indianapolis:

East
Indiana Kidney Center
6635 E 21st Street, Ste 200
Indianapolis, IN 46219
317-353-8900

North
St Vincent Dialysis Center
1717 W 86th Street, Ste 500
Indianapolis, IN 46260
317-338-3038

West
St Vincent Dialysis Center-West
805 Beachway Drive, Ste 100
Indianapolis, IN 46224
317-484-7785

South
Indiana Kidney Center-South
1350 E County Line Rd, Ste L
Indianapolis, IN 46227
317-865-8520

Kokomo:
Saint Joseph Dialysis Center
2350 S Dixon Rd, Ste 450
Kokomo, IN 46902
317-453-0052

Richmond:
Eastern Indiana Kidney Center
1010 North J Street
Richmond, IN 47374
317-962-5611

Greensburg:
Southeastern Indiana Kidney Center
1915 Greensburg Crossing
Greensburg, IN 47240
812-663-6927

Valerie Gates
ISMA Alliance president

The Alliance had a record number of members attend the Medicine Day activities held in January. Alliance members attended an early morning briefing on the status of current legislation. ISMA-A legislative chair, Shirley Becker, introduced Liz Kagan, AMA-Alliance legislative chair, who spoke on national issues affecting medicine and emphasized bills and proposals pertaining to violence in our lives.

Some of these issues include: The Children's Media Protection Act, which calls for a rating system, safe viewing hours and strict enforcement; sexual violence and prevention; and the 1995 Victims Rights Act, which would require HIV testing within 24 hours of an assault, would allow evidence from other crimes to be presented and seeks to standardize sentencing across the country; and the Violence Against Research Act.

In addition, information regarding educational meetings was presented. These meetings include: medicine's candidate; a prescription for political success; AMA Leadership Conference and campaign school. The Alliance is encouraging all counties to assist in voter registration drives.

Indiana Alliance member Ann Wrenn, AMA Alliance secretary, has been slated as the 1996-1997 AMA-A treasurer. This is an honor for Ann, and we wish her well.

Mark your calendars for the Alliance annual convention Oct. 17-19 held in conjunction with the ISMA annual convention. ❑

Former ISMA-A president named Sagamore of Wabash

Rod Ashley, ISMA-A president in 1990-1991, was named a Sagamore of the Wabash March 10 for his many contributions to the Marion community. He has supported many projects of the ISMA Alliance, the Marion Philharmonic Orchestra, the local Civic Theater and the Friends of the Arts. Rod was also honored for his devotion and expertise in the restoration of Hostess House, which is now on the *National Register of Historical Landmarks.* ❑

C. Rodney Ashley and spouse, Susan Rogers, M.D., pictured at the Hostess House, display The Sagamore of the Wabash Award.

Museum exhibit features history of radiology

Oren S. Cooley
Indianapolis

Italian scientist Enrico Salvioni made the first important advancement in early x-ray technology when he invented the fluoroscope in January 1896. This development occurred shortly after Wilhelm Roentgen discovered x-ray in November 1895.

The early fluoroscope allowed physicians and other health care practitioners to view "live" x-ray images on a screen instead of the photographic images made on film by x-rays. Besides allowing a physician to directly observe anatomical features (such as the skeletal structure of the hand), the fluoroscope permitted the examination to occur in a lighted room rather than in the darkened chamber that the photographic images made by x-ray required.

Initially, the fluoroscope, originally called a cryptoscope by Salvioni, consisted of a tube-shaped device with an opening for the eyes at one end and a fluorescent screen at the other end. When x-rays were present, the screen would glow with the characteristic fluorescence. The viewer could see the dark shadow on the screen since an opaque surface existed between the screen and the accompanying x-ray tube.

The device did not leave a permanent shadow on the screen. Consequently, as soon as the generation of x-rays ceased, the fluorescence stopped and the screen became dark.

The same year that Salvioni invented the cryptoscope, American inventor Thomas Edison, an x-ray enthusiast, created the Vitascope, a pyramid-shaped device similar in function to the cryptoscope. This pyramid-shaped device eventually became known as the fluoroscope.

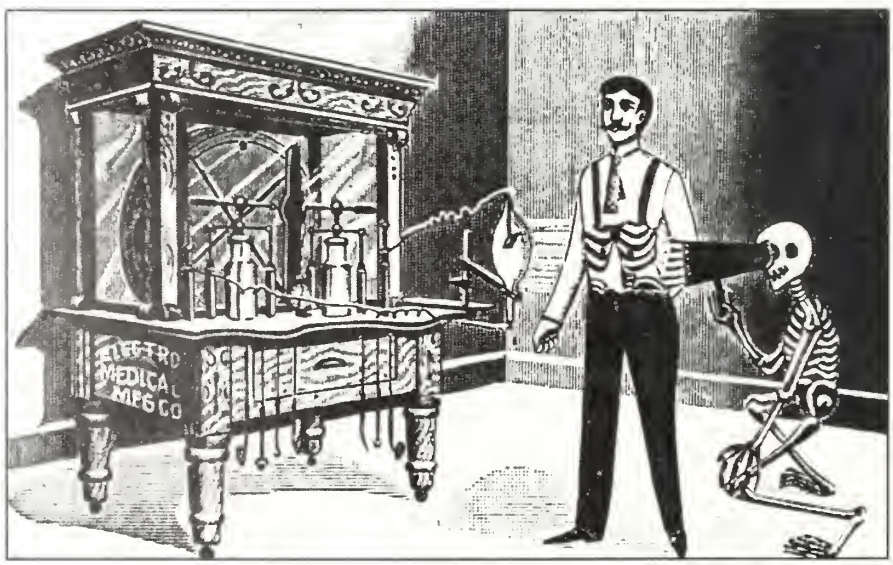
To test the quality of the image, an early fluoroscope operator usually used one hand to hold the device and placed the other hand between the device's screen and the x-ray tube. Then, the operator adjusted the electrical current and voltage until an acceptable picture quality was achieved.

The long time required for the operator's eyes to adjust to the subdued light posed a hazard to the operator and, too often, caused burns to the face, degenerative skin changes in the hands and loss of hair, eyebrows and eyelashes. Eventually, the harmful effects led to lesions, amputations and, ultimately, death.

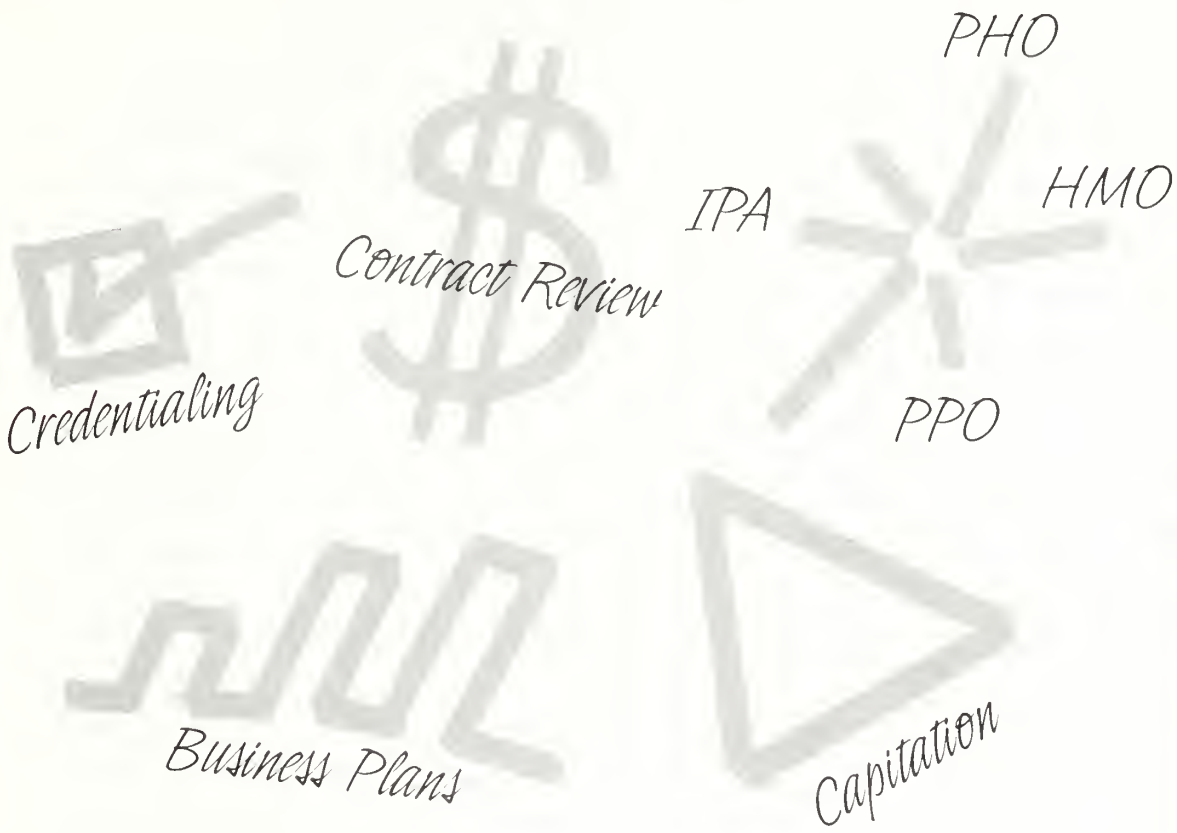
By 1904, health care practitioners began to decrease their use of fluoroscopes because of the increasing realization of the hazards associated with the devices. In addition, the production of more powerful generators and the development of intensifying screens improved radiographic methods by providing better quality photographic images.

The current exhibit at the Indiana Medical History Museum focuses on the history of radiology. The museum, located at 3045 W. Vermont St., Indianapolis, is open from 10 a.m. to 4 p.m., Wednesday through Saturday. For more information, call the museum at (317) 635-7329. ❑

Oren Cooley is director of the Indiana Medical History Museum.



This fanciful illustration from a 1902 advertisement features a skeletal fluoroscopist demonstrating this x-ray unit's fluoroscopic accessories.



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cme calendar

Northside Cardiology

Northside Cardiology will present the following CME courses:

July 13 – Sixth Annual Symposium on Cardiovascular Preventive Medicine for Primary Care Physicians, Radisson Plaza & Suite Hotel, Indianapolis.

Sept. 7 – Practical Arrhythmia Management for the Primary Care Physician, Lafayette, Ind.

October – Treadmill Stress Testing, Northside Cardiology, Indianapolis.

Dec. 13 – 14th Annual Cardiology Update, Westin Hotel, Indianapolis.

For more information, call (317) 338-5050 or 1-800-732-1484.

Methodist Hospital

Methodist Hospital of Indiana will present the "Eighth Annual Dr. Patrick Dolan Lecture" June 14 at Methodist Hospital in Indianapolis.

Wilbur Smith, M.D., a professor and interim head of the department of radiology at the University of Iowa, will present "Understanding Bone Dysplasias," "Liver Imaging in Children" and a case presentation for residents.

For registration information, call Gonzalo Chua, M.D., or Wanda Giles at (317) 929-8250.

Nasser, Smith & Pinkerton

Nasser, Smith & Pinkerton Cardiology Inc. in Indianapolis will present these CME courses:

Aug. 23 – NSP Interventional Symposium, Westin Hotel, Indianapolis.

Sept. 25 – Income vs. Outcome, Ritz Charles, Carmel, Ind.

Oct. 4 – Richter Day, Westin Hotel, Indianapolis.

For more information, call Janet MacAbee, (317) 338-6089.

Indiana University

The Indiana University School of Medicine will present the following CME courses:

May 17 – New Horizons in Medicine.

June 6-7 – ASCO.

All courses will be presented at the University Place Conference Center and Hotel in Indianapolis. For more information, call (317) 274-8353.

Washington University

The Mallinckrodt Institute of Radiology and the Washington University School of Medicine will present "Practical Issues in Leading-Edge Radiology" Oct. 11-13 at The Frontenac Hilton in St. Louis.

The symposium will include discussions on helical CT, CT angiography, MR angiography and current neurointerventional techniques.

For registration information, call Linda Macker at (314) 362-2916.

University of Michigan

The University of Michigan Medical School will sponsor these CME courses:

July 11-14 – 22nd Annual Mackinac Island Course: Advances in the Management of Infectious Diseases, The Grand Hotel, Mackinac Island, Mich.

July 14-16 – 10th Annual Symposium on Breast Disease: Diagnostic Imaging and Current Management, The Grand Hotel, Mackinac Island, Mich.

July 18-21 – Gastroenterology for the Gastrointestinal Consultant, Shanty Creek Resort, Bellaire, Mich.

July 19-21 – Advances in Office Psychiatry: Mood and Anxiety Disorders, The Towsley Center, Ann Arbor, Mich.

July 27-28 – Endocrinology and Diabetes Update, Grand Traverse Resort, Grand Traverse Village, Mich.

Aug. 1-4 – Internal Medicine Update, The Grand Hotel, Mackinac Island, Mich.

To register, call Vivian Woods at (313) 763-1400. ❑

news briefs

IU studies link between low estrogen and Alzheimer's

Indiana University Medical Center researchers are investigating estrogen replacement therapy as a treatment for women with Alzheimer's disease and are looking for study participants.

Research has shown that low estrogen levels in women may have negative effects on the brain and, as a result, may hasten onset of Alzheimer's disease.

Postmenopausal women age 60 and over who are diagnosed with mild to moderate Alzheimer's disease are needed for two national studies. Participants must have no history of cancer of the reproductive system, must not be on estrogen therapy and must be in stable general health.

Participants who qualify will receive gynecological, neurological and psychological examinations and EKG, blood and urine tests free of charge.

For more information, call Nicki Coleman, R.N., study coordinator, (317) 274-1351.

AHCPR offers health care information on Internet

The Agency for Health Care Policy and Research has launched its World Wide Web site – located at http://www.ahcpr.gov/ – to help health care practitioners and consumers make informed health care decisions and to research what works best in health care.

Included are electronic versions of the 17 clinical practice guidelines AHCPR has supported and released thus far.

The major categories available include Offices/Centers, News & Resources, Research Portfolio, Data & Methods, Guidelines & Medical Outcomes and Consumer Health. There is also an electronic catalog to the more than 450 information products generated by AHCPR.

Certification for disability evaluations offered

The American Board of Independent Medical Examiners has launched a national certification program to identify physicians with established credentials and expertise in the evaluation of disability and other physical impairment.

The national certification is designed to distinguish those physicians who are committed to professional excellence and integrity in disability evaluations, who demonstrate appropriate expertise in accordance with ABIME standards and who follow the organization's guidelines of conduct.

ABIME eligibility requirements for physicians include board certification in a recognized medical specialty or medical practice for the past 10 years, the fulfillment of continuing medical education requirements, proven competency through rigorous written examinations and adherence to the ABIME ethical code.

To receive information about ABIME or to order a copy of the 1996 ABIME National Directory, contact Kathy Sydlowski, ABIME, 55 W. Seegers Rd., Arlington Heights, IL 60005, (847) 640-9378.

IU seeks patients for research on strokes

Nine clinical trials are under way at the Indiana University Medical Center to study drugs that might lessen the damaging effects of stroke or prevent stroke patients from having additional strokes.

Some of the studies require that participants enroll within three hours after the onset of stroke symptoms, while others will accept enrollees within 48 hours after the onset of stroke symptoms. Studies of prevention methods will accept patients up to three months after their initial onset of symptoms.

Physicians may refer their patients to the study or patients may enroll on their own. For more information, call (317) 278-0270.

NIH offers report on cochlear implants

A National Institutes of Health (NIH) consensus development statement on cochlear implants in adults and children may be obtained from the NIH Office of Medical Applications of Research. The report was prepared by a panel of experts who considered scientific evidence presented at a Consensus Development Conference at NIH. It contains recommendations and conclusions about cochlear implants.

Free single copies of the consensus statement on cochlear implants in adults and children may be obtained from NIH Consensus Program Information Service, P.O. Box 2577, Kensington, MD 20891, 1-800-644-6627. ❑

obituaries

Harry G. Becker, M.D.
Dr. Becker, 90, a retired Indianapolis surgeon and Army colonel, died Jan. 19, 1996.

He was a 1933 graduate of the University of Illinois College of Medicine. Dr. Becker joined the Army Reserve after serving in World War II. He became commander of the Army Reserve 337th General Hospital at Fort Benamin Harrison in Indianapolis in 1952 and retired as a colonel in 1965.

Dr. Becker served on the staffs of Methodist, Winona, St. Vincent's, Community and Wishard Memorial hospitals. He was a diplomate of the American Board of Surgeons and a fellow of the American College of Surgeons. He had been an industrial physician for Allison Transmission Division of General Motors Corp. and served as associate professor in surgery four years for the Indiana University School of Medicine.

Myron Berkson, M.D.
Dr. Berkson, 73, a Michigan City psychiatrist, died Feb. 4, 1996, at St. Anthony Hospital in Michigan City.

He was a 1952 graduate of the University of Illinois College of Medicine.

Dr. Berkson was a charter member of the Northern Indiana Psychiatric Society and a member of the American Psychiatric Association.

Louis C. Bixler, M.D.
Dr. Bixler, 89, a retired South Bend radiologist, died Jan. 10, 1996, at his home.

He was a graduate of the Indiana University School of Medicine and a U.S. Army veteran of World War II.

Dr. Bixler was affiliated with Radiology Inc. at Memorial Hospital. He was a past president of the St. Joseph County Medical Society and the Indiana Roentgen Society and a fellow of the American College of Radiology.

William W. Drummy Jr., M.D.
Dr. Drummy, 73, a retired Terre Haute internist, died Feb. 16, 1996.

He was a 1948 graduate of Harvard Medical School. He was an Air Force flight surgeon and served as chief of medical service at McDill Air Force Base Hospital in Tampa, Fla., and as chief of medical professional services at Ladd Air Force Base hospital in Fairbanks, Alaska.

Dr. Drummy had practiced in Terre Haute since 1957. He was the chairman and co-founder of the original coronary care unit at St. Anthony's Hospital, where he also helped start the first respiratory care unit in Terre Haute. He had been an associate professor of medicine and community health services at the Indiana University School of Medicine and a clinical instructor of medicine and head of cardiology teaching at the Indiana State University Division of the IU School of Medicine. Dr. Drummy was the former director of the Vigo County Tuberculosis Clinic, the past president of the Owen County Board of Health and former medical director of the student health department at ISU. He had served as chairman of the department of medicine at Terre Haute Regional Hospital.

David C. Gastineau, M.D.
Dr. Gastineau, 71, a retired Fort Wayne radiation oncologist, died Jan. 16, 1995.

He was a 1947 graduate of the Indiana University School of Medicine.

Dr. Gastineau was a founding member of the American Society of Therapeutic Radiology and helped establish the Parkview Oncology Center in Fort Wayne.

Chester J. Kmak, M.D.
Dr. Kmak, 65, formerly of Munster, died March 8, 1996, in Marco Island, Fla., where he had lived for 1 1/2 years.

He was a 1956 graduate of the Indiana University School of Medicine.

Dr. Kmak was an obstetrician and gynecologist.

Robert W. Kohne, M.D.
Dr. Kohne, 71, a Lafayette family practice physician, died March 1, 1996.

He was a 1953 graduate of the Indiana University School of Medicine. While serving with the U.S. Navy during World War II, he was detached to a British intelligence unit, working with the French underground. He received the French Legion of Honor from Gen. Charles de Gaulle and later the French Legion of Merit from President de Gaulle. He served in the South Pacific aboard a ship with the Marine Corps and the U.S. Navy. For his service, he received two personal presidential commendations.

Dr. Kohne had a practice in Lafayette and was Lafayette health officer for 23 years and city police surgeon for 25 years. He was on

the staffs of St. Elizabeth and Home hospitals for 41 years. He was a life member of the American Academy of Family Physicians. In 1991, he was named a Sagamore of the Wabash by Gov. Evan Bayh.

Everett E. Mason, M.D.
Dr. Mason, 84, an Evansville family practice physician, died Feb. 20, 1996, at his home.

He was a 1936 graduate of the Indiana University School of Medicine. During World War II, he was a colonel and commander of the 58th Medical Battalion serving in North Africa and Europe.

Dr. Mason was a family physician and surgeon for 55 years.

Jack McKittrick, M.D.
Dr. McKittrick, 83, a Washington, Ind., family practice physician, died Feb. 27, 1996, at Carmel (Ind.) Care Center.

He was a 1936 graduate of the Indiana University School of Medicine. He was a flight surgeon during World War II, stationed in England with the Eighth Air Force's 95th Bomb Group, which earned three Presidential Citations.

Dr. McKittrick was in practice for 45 years, retiring in 1982. He was a member of the American Legion and a former member of the board of directors of Washington National Bank.

Felix Millan, M.D.
Dr. Millan, 67, a physical medicine and rehabilitation physician in East Chicago, died March 7, 1996, at his home in Munster.

He was a 1954 graduate of Facultad de Medicina Universidad Nacional Autonoma in Mexico.

Dr. Millan had practiced in East Chicago since 1975. He was on the staffs of Munster Community Hospital, St. Catherine Hospital and Our Lady of Mercy Hospital. He was a fellow of the Royal Society of Health in London and a fellow of the American College of Legal Medicine.

Perry F. Seal, M.D.
Dr. Seal, 80, a retired Brookville family physician, died Jan. 24, 1996, at Margaret Mary Community Hospital in Batesville.

He was a 1942 graduate of the University of Cincinnati College of Medicine and an Army veteran of World War II.

Dr. Seal opened his practice in Brookville in 1946 and retired in 1993. He was the Franklin County Board of Health officer for 35 years and was the athletic program physician for the Brookville and Franklin County high schools for more than 40 years. He was a member of the American Academy of Family Physicians.

Henry A. Staunton, M.D.
Dr. Staunton, 81, a retired South Bend family physician, died Oct. 7, 1995.

He was a 1940 graduate of the St. Louis University School of Medicine.

Dr. Staunton, who retired in 1990, had been on the staffs at St. Joseph Medical Center and Memorial Hospital in South Bend and St. Joseph Hospital in Mishawaka. He was a member of the American Academy of Family Physicians.

Roland B. Wilson, M.D.
Dr. Wilson, 84, a retired Fort Wayne family physician, died Jan. 28, 1996, at St. Joseph Medical Center.

He was a 1944 graduate of the Howard University College of Medicine and served in the Army Medical Corps.

Dr. Wilson, who practiced in Fort Wayne for 45 years, was on the staffs at the city's three hospitals. He was active in civil rights and served as a physician in the march to Selma, Ala., with Dr. Martin Luther King Jr. He also collected supplies for the march before he joined in. Dr. Wilson helped found the Frontiers Club to provide wheelchairs to people who couldn't afford them. He received the Marjorie D. Wickliffe Award in 1995 from the Fort Wayne branch of the National Association for the Advancement of Colored People. ❑

people

Dr. Myron H. Weinberger, professor of medicine and director of the Hypertension Research Center at the Indiana University School of Medicine, has received the Robert Tigerstedt Award from the American Society of Hypertension. The award is given every two years for outstanding research in hypertension.

Dr. Dung D. Nguyen, a resident in the Department of Anesthesiology at the Indiana University School of Medicine and an ISMA alternate trustee, was co-author of an article titled "Medical Student Abuse During Third-Year Clerkships" that was published in the Feb. 7, 1996, issue of the *Journal of the American Medical Association*.

Dr. Richard C. Rink of the James Whitcomb Riley Hospital for Children and **Dr. Tim E. Taber** of Methodist Hospital in Indianapolis received research grants from the National Kidney Foundation of Indiana. Dr. Rink's research project is "The Natural History of Nephrocalcinosis in the Premature Infant," and Dr. Taber's project is "Use of Low Molecular Weight Heparin (Enoxaparin) in the Prevention of Neointimal Hyperplasia at the Venous Anastomosis in PTFE hemodialysis Arterio-Venous Conduits (Grafts)."

Accomplishments and activities of physicians at the Indiana Hand Center of Indianapolis include the following: **Dr. James W. Strickland** was the guest lecturer at the annual John F. LeCocq Lectureship in Orthopaedics in Seattle, Wash.; his talks included "Specialization: The Past, the Present, the Future" and "The Scientific Rationale of Improved Flexor Tendon Repair." Dr. Strickland presented the first Daniel Riordan Lectureship at Tulane University in New Orleans; he spoke on "Current Trends in Flexor Tendon Repair" and "The Daniel Riordan Lecture: Specialization in Orthopaedics." Dr. Strickland was reelected to the board of directors of the American Academy of Orthopaedic Surgeons. **Dr. Hill Hastings II** received the Innovation Award for his contributions to the AO Hand Study Group; he was recognized for his contribution in the development of the distal radius plate and percutaneous forceps and for his contributions to the AO Hand Study Group of the Technical Commission. **Dr. Robert M. Baltera** and **Dr. Jeffrey A. Greenberg** have passed the Certificate of Added Qualification in hand surgery. Dr. Greenberg authored a paper titled "Salvage of the Failed Darrach Procedure" that was published in the November 1995 issue of the *Journal of Hand Surgery*. Dr. Greenberg spoke on "Dynamic Dissociative Scapholunate Instability" as part of a panel on carpal instability at the annual meeting of the American

Physician Recognition Award recipients

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

November 1995
Andrews, Ronald K., Greenfield
Baker, Mason R., Evansville
Castor, Conrad P., Schererville
Combs, Kenneth G., Evansville
Davison, Bruce A., Columbus
Dolembo, John M., Zionsville
Egnatz, Charles D., Schererville
Goyne, Cheryl, Valparaiso
House, Jerry L., Indianapolis
Hutter, George E., Carmel
Irick, Robert M., Bloomington
Kamen, Jack M., Indianapolis
Kelly, George G., Munster
Levine, Michael D., Carmel
Lewis, Merral B., Evansville
Marnocha, Kenneth E., Zionsville
McAree, Francis E., Indianapolis
Nakamura, Takamitsu, Munster
Rayes, Hassan, Princeton
Sasso, Rick C., Indianapolis
Spence, William C., Bloomington
Storm, Richard M., Indianapolis
Willage, Mark B., Madison
Zeph, Richard D., Carmel

December 1995
Brantly, James M., Indianapolis
Byrne, Frank D., Fort Wayne
Diaz, David R., Indianapolis
Domingo, Ricardo C., Greensburg
Ferree, Mary M., Indianapolis
Frost, Marc L., Indianapolis
Goode, Roy L., Columbus
Mellinger, Michael O., LaGrange
Munoz, Jose C., Fort Wayne
Poor, Maria C., Indianapolis
Titcomb, Clifton P., Fort Wayne
Von Stein, G. Alan, Trafalgar
Zehr, Brian P., Fort Wayne

January 1996
Brown, Michael R., Terre Haute
Crabb, Daniel G., Carmel
Feldman, Howard E., Munster
Gelfman, Daniel M., Anderson
Healey, Diane W., Carmel
Kintanar, Thomas A., Fort Wayne
Markham, Raymond E., Indianapolis
Masbaum, Ned P., Carmel
Mattox, Dean L., Angola
Nicholas, Thomas D., Rockville
Sartore, Gilbert A., Evansville
Vorwald, Mary J., Zionsville
Wang, Arthur F., Mishawaka
Wass, Justin L., Franklin

Association of Hand Surgery in Palm Springs, Calif.

Dr. Rick C. Sasso of Indianapolis Neurosurgical served as a faculty member at an AO spinal instrumentation course in Paoli, Pa.; he lectured on transarticular screw fixation of the C1-C2 joint and anterior fixation of odontoid fractures.

Dr. Douglas J. Van Putten, a LaPorte ophthalmologist specializing in plastic, reconstructive, cosmetic and laser surgery, was appointed to the Committee of Young Surgeons of the American College of Surgeons.

Dr. Rhonda S. Trippell of Bloomington was named a diplomate of the American Board of Obstetrics and Gynecology.

Accomplishments and activities of physicians at Northside Cardiology in Indianapolis include the following: **Dr. Thomas J. Linnemeier** spoke on "OSTI: Optimal Stent Implantation Protocol" during International Congress IX on Endovascular Interventions in Scottsdale, Ariz., and gave a presentation on "The Active Guide Catheter: A Lost Art Form or Obsolete Technology" at the Andreas Gruentzig Society meeting in Aruba. Dr. Linnemeier was appointed governor for Indiana and Michigan for the Society for Cardiac Angiography and Interventions. **Dr. Eric Prystowsky** co-chaired the International Review course on Cardiology for Chinese physicians in Beijing; he also gave four presentations and participated in a radiofrequency ablation. **Dr.**

Evan Scott Melrose, a student at the Indiana University School of Medicine, receives an American Medical Association/Glaxo Wellcome Achievement Award from Nancy W. Dickey, M.D., chair of the AMA's Board of Trustees. The award was presented at the AMA's National Leadership Conference. Melrose has officially represented IU at several national and state conferences through his involvement with many organizations. He successfully led grassroots efforts to lobby Indiana Congressional delegates and participated in the AMA government relations internship in Washington, D.C. He founded the unique program, "Project Magic," which conducts physical therapy for children through teaching them magic.

Gregory C. Risk, M.D., a third-year emergency medicine resident at Methodist Hospital in Indianapolis, receives the American Medical Association/ Glaxo Wellcome Achievement Award from Nancy W. Dickey, M.D., chair of the AMA's Board of Trustees. The award was presented at the AMA's National Leadership Conference. Dr. Risk serves as the co-chair of the Methodist Hospital's Lifeline Helicopter/Emergency Medical Services Committee. He has been active in the Indiana State Medical Association and is current president of the ISMA Resident Medical Society. He has served as a delegate to the AMA. Dr. Risk has served as the Emergency Medicine Resident Association representative to the Society for Academic Emergency Medicine's Residency Committee.

people

Morton Tavel conducted a seminar on "Cardiac and Pulmonary Auscultation" in Chicago under the auspices of the American College of Chest Physicians. **Dr. Richard Gordon** was co-author of an article titled "Valvulitis Involving a Bioprosthetic Valve in a Patient with Systemic Lupus Erythematosus" that was published in the January/February 1996 issue of the *Journal of the American Society of Echocardiography*.

Accomplishments and activities of physicians at the Methodist Sports Medicine Center in Indianapolis include the following: **Dr. K. Donald Shelbourne** was moderator for a discussion on anterior cruciate ligament reconstruction rehabilitation at the annual meeting of the American Academy of Orthopaedic Surgeons (AAOS) in Atlanta. **Dr. Thomas E. Klootwyk** was inducted as a fellow of the AAOS at the group's annual meeting in Atlanta; he also spoke on anterior cruciate ligament reconstruction rehabilitation at the meeting. **Dr. Arthur C. Rettig** spoke on "Acute Stable Scaphoid Fractures: Whether to Fix with Herbert Screw" at the AAOS annual meeting; he gave presentations on "Hand and Wrist Injuries in Athletes," "How I Manage Scaphoid Fractures" and "Contribution of the Trunk and Back to Overhead Throwing" at the advanced team physician course sponsored by the American College of Sports Medicine, the American Medical Society for Sports Medicine and the American Orthopaedic Society for Sports Medicine in Scottsdale, Ariz.

Dr. Stephen W. Perkins, an Indianapolis facial plastic and reconstructive surgeon, gave an overview of "Anesthesia for Nasal Surgery and Steps for Rhinoplasty" and was a panelist discussing "Case Management of Cosmetic and Functional Approach to Rhinoplasty" at "Rhinoplasty '96," sponsored by the Educational and Research Foundation for the American Academy of Facial Plastic and Reconstructive Surgery in Atlanta, Ga. He spoke on "Facial Resurfacing" and "Forehead Lifting: Endoscopic vs. Open" at a symposium sponsored by the American Academy of Facial Plastic and Reconstructive Surgery in Snowmass, Colo.

Dr. Maurice E. Arregui of Indianapolis spoke on laparoscopic and endoscopic ultrasound during a program on "Diagnostic and Interventional Ultrasound for Surgeons" in Orlando, Fla. He was appointed program chairman for the "Ultrasound for the General Surgeon" course held during the World Congress on Endoscopic Surgery in Philadelphia.

Dr. Richard D. Zeph, a Carmel facial plastic surgeon, spoke on open structure tip principles at a symposium sponsored by the American Academy of Facial Plastic and Reconstructive Surgery in Snowmass, Colo.

Dr. William Beeson, an Indianapolis facial plastic and reconstructive surgeon, was elected to the American Academy of Cosmetic Surgery Board of Trustees. He spoke on hair transplant using CO_2 lasers, endoscopic facial surgery and anatomy of the forehead and face at the academy's annual scientific meeting.

Dr. Greg Hardin of SCORE (Specialty Centers for Orthopaedic and Rehabilitative Excellence) in Indianapolis presented a lecture on holmium laser assisted capsular shift shoulder stabilization surgery and was course faculty for the cadaver lab at the Musculoskeletal Laser Society meeting in Lake Tahoe, Nev.

Dr. Vidyasagar Tumuluri, an Indianapolis hand surgeon, received a plaque from the March of Dimes for raising $56,000 for Walk America.

Dr. Miles J. Jones, a LaPorte pathologist, was awarded status as a Diplomate: Board Certified Forensic Examiner of the American Board of Forensic Examiners.

Dr. Rama Jager, medical director of Colon and Rectal Care in Indianapolis, is the co-editor of a new textbook titled *Laparoscopic Colorectal Surgery*, available through Churchill Livingstone.

Dr. John F. Williams Jr., professor of medicine and associate dean at the Indiana University School of Medicine and director of Wishard Health Services, received the Distinguished Fellowship Award from the American College of Cardiology. The award is given to a fellow of the college who has preformed outstanding service in the interest of the college.

Dr. Douglas P. Zipes, distinguished professor of medicine and professor of pharmacology and toxicology at the Indiana University School of Medicine, has received the Distinguished Scientist Award from the American College of Cardiology. He was honored for his research on the role of the autonomic nervous system in the control of the normal and the pathological heart.

Dr. Frank P. Lloyd Sr. of Indianapolis received a Drum Major Award from the Circle City Frontiers Service Club. He was honored for his outstanding leadership in community service.

Dr. Thomas P. O'Rourke of Vincennes has been certified by the American Board of Obstetrics and Gynecology.

Dr. W. Rodger Funderburg Jr. of Vincennes has been certified by the American Board of Anesthesiology.

Dr. Guy H. Waldo, a Bedford internist, has retired. He was one of the original physicians who joined Edgewood Clinic in 1958.

Dr. Olaf B. Johansen of Mooresville, **Dr. Jonathan L. Schmidt** of Muncie and **Dr. Rami Saydjari** of Crawfordsville were named fellows of the American College of Surgeons.

Dr. Henry Bock, an emergency medicine specialist at Methodist Hospital in Indianapolis, received the John Kassis Award from the Marion County Hazardous Materials Responders. The award honors a citizen who has made extraordinary contributions to the program.

Dr. Scott B. Edwards, medical director of the Occupational Medicine Network of St. Joseph's Medical Center in South Bend, has become board certified in internal medicine.

Dr. Eldon E. Baker has retired after 37 years in family practice in Delphi.

Dr. Gary A. Frick of the Heart Center of Marion has become board certified in cardiology.

Dr. Ronald H. Scheeringa, a Fort Wayne internist, was elected a fellow of the American College of Physicians.

New ISMA members

Sudha Alankar, M.D., Scottsburg, pediatrics.

Suresh Alankar, M.D., Scottsburg, general surgery.

Timothy J. Aldridge, D.O., Plymouth, internal medicine.

Stephen D. Allen, M.D., Indianapolis, anatomic pathology.

Tonya L. Allen, M.D., Muncie, clinical pathology.

Ifeanyi B. Anigbo, M.D., Gary, family practice.

Shahabul S. Arfeen, M.D., Gary, nephrology.

Stephen L. Baker, M.D., Columbus, neurology.

Andrew R. Baron, M.D., Mishawaka, family practice.

Todd A. Baxter, M.D., Columbus, pediatrics.

Stephen H. Berghofer, M.D., Elwood, family practice.

Brion A. Bertsch, M.D., Muncie, family practice.

Padmanaabha R. Betina, M.D., Goshen, internal medicine.

Anand D. Bhuptani, M.D., Terre Haute, pulmonary diseases.

Suzanne Bielski, M.D., Fishers, pediatrics.

Richard L. Bohnenkamp, M.D., Muncie, anatomic/clinical pathology.

Joel Braunstein, D.O., Elkhart, family practice.

Robert J. Champer, M.D., Muncie, ophthalmology.

Lori L. Checkley, M.D., South Bend, family practice.

Kenneth Y. Chern, M.D., Muncie, orthopaedic surgery.

Stephen D. Coleman, M.D., Muncie, family practice.

Jeffrey C. Cooper, M.D., Lafayette, urological surgery.

Alain J. Couturier, M.D., Mishawaka, internal medicine.

Goran Cvijanovic, M.D., Muncie, internal medicine.

Francis M. Cyran, M.D., Auburn, psychiatry.

Bart J. DeBrock, M.D., Vincennes, urological surgery.

Maria G. Del Rio, M.D., Evansville, neonatal-perinatal medicine.

Douglas J. Delafield, M.D., Franklin, family practice.

Stephen R. Depperman, M.D., Indianapolis, ophthalmology.

Leah G. Dickerson, M.D., Jeffersonville, psychiatry.

Patrick Doolan, M.D., Lebanon, family practice.

Francis Duque, M.D., Jeffersonville, anesthesiology.

Husameddin R. El Bakri, M.D., Gary, family practice.

Susan M. Emmick, M.D., Plainfield, pediatrics.

Gene V. Fedor, M.D., Griffith, orthopaedic surgery.

James M. Forde, M.D., Valparaiso, diagnostic radiology.

Frank W. Fortuna, M.D., Indianapolis, family practice.

Dennis E. Frazier, M.D., Michigan City, family practice.

Edward T. Fry, M.D., Indianapolis, cardiovascular diseases.

Tom N. Galouzis, M.D., Hobart, general surgery.

David G. Gross, D.O., Merrillville, ophthalmology.

Ashraf H. Hanna, M.D., Fort Wayne, family practice.

Paras Harshawat, M.D., Terre Haute, psychiatry.

Kenneth V. Harvey, M.D., Evansville, psychiatry.

Steven R. Hayes, M.D., Evansville, anesthesiology.

Sandra K. Hensley, M.D., Sellersburg, pediatrics.

John C. Hilgenberg, M.D., Leesburg, anesthesiology.

David J. Huddleston, M.D., Muncie, clinical pathology.

Eric M. Humphreys, M.D., Vincennes, anesthesiology.

Jerry L. Jamison, M.D., Clarksville, internal medicine.

Leo Dean Jansen, M.D., Warsaw, orthopaedic surgery.

Rosemarie M. Jeffery, M.D., Muncie, internal medicine.

Steven L. Jones, M.D., Muncie, pathology, hematology.

Ramesh B. Kalari, M.D., Bedford, gastroenterology.

John D. Keen, M.D., Greenwood, family practice.

Rizwan R. Khan, M.D., Winchester, pediatrics.

Gail S. King, M.D.,

people

Noblesville, obstetrics and gynecology.

Deanna M. Knoll, D.O., Plymouth, pediatrics.

Philip C. Krause, M.D., Lafayette, cardiovascular diseases.

Suresh Lakshminarayanan, M.D., Hammond, nephrology.

Howard S. Lazarus, M.D., New Albany, ophthalmology.

Carl H. Linge, M.D., Evansville, radiology.

Scott A. Lintner, M.D., Indianapolis, orthopaedic surgery.

Michael A. Litwiller, M.D., Greenwood, child psychiatry.

Won-Shick Loh, M.D., Munster, cardiovascular diseases.

Lynn M. Losby, M.D., North Manchester, family practice.

Polly E. Lybrook, M.D., Bloomington, psychiatry.

William J. Lynn, M.D., Indianapolis, family practice.

Norman G. MacDonald, M.D., Warsaw, family practice.

Calvin J. Maestro Jr., M.D., Indianapolis, family practice.

A. Gabriel Maijub, M.D., Peru, family practice.

Anne M. Majewski, D.O., LaPorte, pediatrics.

Lance A. Maki, M.D., Plymouth, obstetrics and gynecology.

Paul R. Mark, M.D., South Bend, obstetrics and gynecology.

Steven S. Maves, M.D., Indianapolis, anesthesiology.

Stephen L. McConnell, M.D., Bloomington, emergency medicine.

Katrina K. McGillivray, D.O., Columbus, family practice.

Jonathan S. McGlothan, M.D., Muncie, ophthalmology.

John G. McGue, M.D., LaPorte, diagnostic radiology.

Joseph E. Meiners, M.D., New Albany, pediatrics.

Stacey E. Merritt, M.D., Corydon, emergency medicine.

Jane E. Messemer, M.D., Muncie, pediatrics.

Mark A. Meyer, M.D., Indianapolis, family practice.

Norman Mindrebo, M.D., Indianapolis, orthopaedic surgery.

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M.A. Karim Moshref, M.D., Fort Wayne, family practice.

Michael W. Mull, M.D., Peru, family practice.

Douglas M. Murphy, M.D., Munster, orthopaedic surgery.

Jean P. Orr, M.D., Noblesville, anesthesiology.

Jagdish R. Patel, M.D., Hammond, internal medicine.

David L. Patterson, M.D., Indianapolis, allergy and immunology.

Branko D. Pejic, M.D., Gary, family practice.

Jeffrey M. Peterson, M.D., Indianapolis, family practice.

John P. Phillips, M.D., Indianapolis, child neurology.

James L. Qualkinbush, M.D., Indianapolis, anesthesiology.

Vijay M. Raghavan, M.D., Hardinsburg, internal medicine.

Robert J. Rapoport, M.D., Indianapolis, radiology.

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Dean B. Ricks, M.D., Muncie, clinical pathology.

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Helena L. Sagalovsky, M.D., Crown Point, internal medicine.

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Reginald Sandy, D.O., Vincennes, internal medicine.

William L. Smits, M.D., Fort Wayne, pediatric pulmonology.

Michael E. Smothers, M.D., Albany, family practice.

Beth A. Snider, M.D., Anderson, anesthesiology.

Rahul Somani, M.D., Crown Point, radiology.

Edward L. Stevens Jr., M.D., Fort Wayne, pediatrics.

Deborah C. Stokes, D.O., Muncie, neurology.

Gregory M. Sutliff, M.D., Bloomington, cardiovascular diseases.

Floyd J. Swenson, M.D., Bloomington, family practice.

Joan K. Szynal, M.D., Goshen, physical medicine and rehabilitation.

Keith Thomas, M.D., Princeton, anesthesiology.

Scott G. Thomas, M.D., South Bend, general surgery.

Ajit K. Tiwari, M.D., Muncie, ophthalmology.

Roger J. Van Orsdoll, M.D., Elkhart, pediatrics.

Neal J. VanNess, M.D., Warsaw, general surgery.

Robert A. Vogt, M.D., Evansville, diagnostic radiology.

Esperanza A. Wade, M.D., Corydon, anesthesiology.

Denise A. Ward, D.O., Elkhart, anesthesiology.

Charles M. Ware Jr., M.D., Mishawaka, orthopaedic surgery.

Marianne Watkins, M.D., Fort Wayne, obstetrics and gynecology.

Franklin C. Wefald, M.D., South Bend, cardiovascular diseases.

Ann T. Wendecker, M.D., Terre Haute, radiology.

Phillip L. Whitfield, M.D., Kokomo, general practice.

Michael A. Wohlberg, M.D., Jasper, diagnostic radiology.

Eric L. Wymer, M.D., Mooresville, internal medicine.

Nageswar R. Yelavarthi, M.D., Crown Point, anesthesiology.

Lisa A. Youngblood, M.D., Indianapolis, family practice. ❑

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Annual Meeting: to be announced
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11 - Pres: William Mohr, Kokomo
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Annual Meeting: Sept. 11, 1996
12 - Pres: David Haines, Warsaw
Secy: Robert Dykstra, Fort Wayne
Annual Meeting: Sept. 10, 1996
13 - Pres: Mohammad Arab, LaPorte
Secy: Donald Smith, South Bend
Annual Meeting: March 20, 1996

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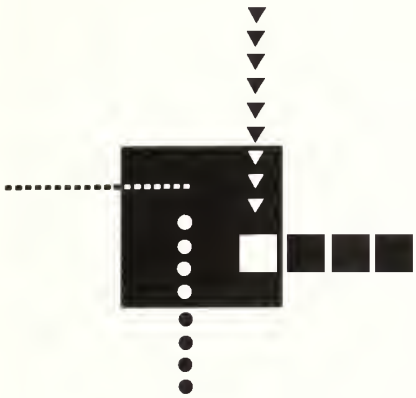

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Highlights of the June meeting include an information exchange, which builds on the December 1995, program theme, "Creating the Future and Getting There First." Physicians will:

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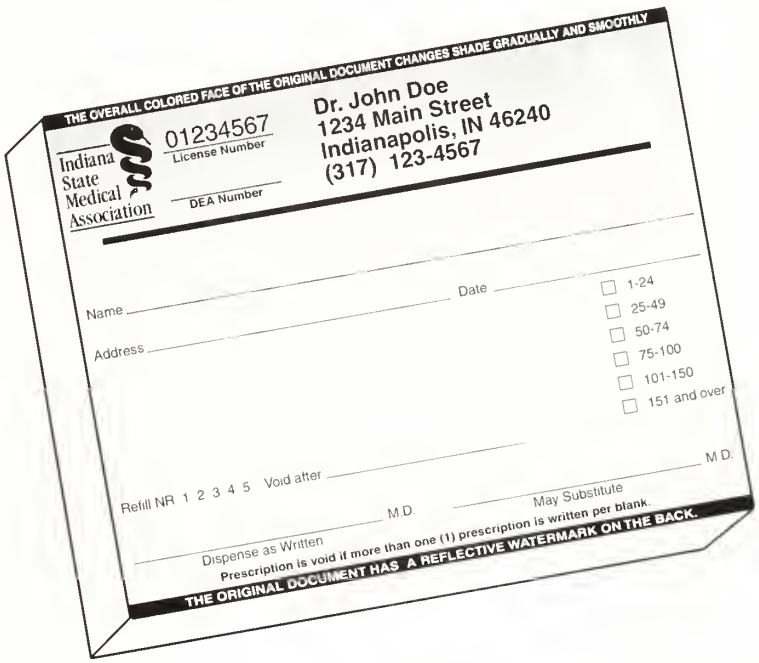

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1,000	■ $1,000 calendar year deductible, $2,000 per family ■ Stop-Loss limit $5,000 per person, $10,000 per family	✓	✓	
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- $1,500 maximum dental benefit per person per calendar year

Indiana State Medical Association

Available through the ISMA Insurance Agency.

For more information regarding these coverages contact the ISMA Insurance Agency.

1-800-442-ISMA